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ABSTRACT

This two-part handbook presents information on educating adolescents about reproductive and sexual health issues. "Book One, Understanding the Adolescents and Their Reproductive and Sexual Health: Guide to Better Educational Strategies" focuses on the demographic profile of adolescents as well as their fertility, sexual behavior, incidence of sexually transmitted diseases, HIV/AIDS, teen pregnancy, and abortion. It analyzes factors and problems associated with adolescent reproductive and sexual health and the causes of unhealthy development. Recommendations are provided to address various issues and concerns about adolescent reproductive health. "Book Two, Strategies and Materials on Adolescent Reproductive and Sexual Health Education" provides actual strategies, techniques, and guidelines for integrating content on adolescent reproductive and sexual health into the curriculum. It offers a comprehensive analysis of the gaps and problems in introducing reproduction and sexuality issues into the curriculum, responses of various countries, and the need for carrying out a more systematic program of education. This volume also defines what a reproductive and sexual health education program should cover, strategies that can be used to introduce an educational program on the subject, and elements to consider in formulating the curriculum. (Both volumes contain approximately 90 references.) (SM)

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Book One, Understanding the Adolescents and Their Reproductive and Sexual Health: Guide to Better Educational Strategies

[and]

Book Two, Strategies and Materials on Adolescent Reproductive and Sexual Health Education

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# Handbook for Educating on Adolescent Reproductive and Sexual Health

*Book One: Understanding the Adolescents and their Reproductive and Sexual Health: Guide to Better Educational Strategies*

UNESCO PROAP Regional Clearing House
on Population Education and Communication

United Nations Population Fund

Bangkok, 1998

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# Handbook for Educating on Adolescent Reproductive and Sexual Health

*Book One*
*Understanding the Adolescents and their Reproductive and Sexual Health: Guide to Better Educational Strategies*

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on Population Education and Communication

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# PREFACE

According to ICPD POA, the reproductive health needs of adolescents as a group have been largely ignored to date by existing reproductive health services. To meet the reproductive and sexual health needs of adolescents, information and education should be provided to them to help them attain a certain level of maturity required to make responsible decisions. In particular, information and education should be made available to adolescents to help them understand their sexuality and protect them from unwanted pregnancies, sexually transmitted diseases and subsequent risk of infertility. This should be combined with the education of young men to respect women's self-determination and to share responsibility with women in matters of sexuality and reproduction.

Motherhood at a very young age entails a risk of maternal death that is much greater than average, and the children of young mothers have higher levels of morbidity and mortality. Early child bearing continues to be an impediment to improvements in the educational, economic and social status of women in all parts of the world. Overall for young women, early marriage and early motherhood can severely curtail educational and employment opportunities and are likely to have a long-term, adverse impact on their and their children's quality of life.

In many societies, adolescents face pressures to engage in sexual activity. Young women, particularly low-income adolescents are especially vulnerable. Sexually active adolescents of both sexes are increasingly at high risk of contracting and transmitting sexually transmitted diseases, including HIV/AIDS; and they are typically poorly informed about how to protect themselves.

The crucial and critical factor that could contribute in alleviating or preventing adolescent reproductive health problems lie in education, information and communication. Adolescents should be given the opportunities to exercise their rights to reproductive health education, information and care or services. However, health care and information providers must safeguard their rights to privacy, confidentiality, and informed consent, respecting cultural values and religious beliefs. Any programmes on reproductive health should include support mechanisms for the education and counselling of adolescents in the areas of gender relations and equality, sexual abuse and violence against adolescents, responsible sexual behaviour, responsible family planning practices, family life, reproductive health, sexually transmitted diseases including HIV/AIDS.

Information and education programmes should not only be targetted at the youth but also at all those who are in a position to provide guidance and counselling to them, particularly, parents and families, service providers, schools, religious institutions, mass media and peer groups. These programmes should also involve the adolescents in their planning, implementation and evaluation.

Being a sensitive and often, controversial area, adolescent reproductive and sexual health issues and information are very often difficult to handle and disseminate. Furthermore, the contents do not only deal with factual and knowledge-based information but more importantly, need to deal with attitudinal and behavioural components of the educational process. This in turn, requires that the educators, information and service providers should be equipped with adequate knowledge and skills in handling sensitive topics, in promoting clarification of values and problem solving as well as ensuring involvement of



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adolescents in the analysis of their own values and beliefs with regard to such topics. To assist in developing such expertise in dealing with adolescent reproductive and health issues, this handbook is being developed for educators, information providers, counsellors, service providers, and peer educators. It will basically serve as a reference tool, which will provide guidelines, teaching/training strategies and actual sample lessons or activities to be used in counselling and educating adolescents in various aspects of reproductive and sexual health.

## Objectives

This handbook is a result of information repackaging programme of the Regional Clearing House on Population Education. Information and materials on adolescent reproductive health is rapidly growing. The Clearing House has initiated a collection and database on this subject and countries have started to contribute the materials that they have so far produced. These materials in turn need to be shared with the countries in synthesized, processed and consolidated forms. With the assistance of **Ms. Sunanda Krishnamurty**, consultant, **Mr. Sheldon Jacobs**, consultant and **Ms. Carmelita L. Villanueva**, Chief, Regional Clearing House on Population Education, this repackaging effort resulted in two volumes.

The first volume entitled, **Book One: Understanding the Adolescents and Their Reproductive and Sexual Health: Guide to Better Educational Strategies** focuses on the demographic profile of the adolescents, as well as their fertility, sexual behaviour, incidence of STDs, HIV/AIDS, teen pregnancy and abortion, and the like. It also analyses the factors and problems associated with adolescent reproductive and sexual health as well as the causes of the unhealthy development of adolescents. Recommendations are provided by the author to address the various issues and concerns on adolescent reproductive health, which includes education among others.

Volume two entitled, **Book Two: Strategies and Materials on Adolescent Reproductive and Sexual Health Education** provides the actual strategies, techniques and guidelines for integrating contents on adolescent reproductive and sexual health into the curriculum. It provides as a backgrounder a comprehensive analysis of the gaps and problems in introducing reproductive and sexuality issues into the curriculum, the response of the countries and the need for carrying out a more systematic programme on it. More importantly, it provides a definition of what a reproductive and sexual health education covers, the various strategies that can be used to introduce an educational programme on it and lastly, the elements that can be considered in formulating the curriculum on the subject.

The objectives of the two volumes are:

1) To develop better understanding of the issues and problems associated with adolescent reproductive and sexual health in order to deal with them in a comfortable and effective manner

2) To develop skills or ways and means of integrating messages on adolescent reproductive and sexual health into the curriculum

3) To provide ready reference of exemplary strategies and curriculum/ training materials as tools in teaching, training and counselling on adolescent reproductive and sexual health

4) To provide the educators with an over-all view of the literature that exist on the subject of adolescent reproductive and sexual health

## Sources

The two volumes were compiled using the available materials in the Regional Clearing House on Population Education collection, from the UNFPA documents and materials, as well as from the UNFPA Country Support Teams whose Advisers collect these materials arising from CST technical meetings held every year. A few others were obtained from other international organizations and countries in the region. Acknowledgment is due to the staff of the Clearing House for assisting the authors in literature searching, retrieving, photocopying and putting the bibliography in order.

# SECTION ONE: DEMOGRAPHIC PROFILE OF ADOLESCENTS

## Who are the youth and who are adolescents?

- **WHO defines adolescence as the period between 10 and 19 years of age, which broadly corresponds to the onset of puberty and the legal age for adulthood.**
- **The UN has defined "youth" as those in the age range 15- 24, partly overlapping WHO definition.**

Commencement of puberty is usually associated with the beginning of adolescence. The end of adolescence on the other hand, varies from culture to culture. In some societies, adolescents are expected to shoulder adult responsibilities well before they are adults; in others, such responsibilities come later in life. Although it is a transitional phase from childhood to adulthood, it is the time that the adolescents experience critical and defining life events – first sexual relations, first marriage, first childbearing and parenthood.

- **In most parts of the world, sexual relations begin during adolescence. It is a critical period which lays the foundation for reproductive health of the individual's lifetime. Therefore, "adolescent reproductive and sexual health involves a specific set of needs distinct from adult needs."[1]**

All over the world, age at puberty is declining while age at marriage is rising. Because of an increase in the amount of time young people spend between puberty and first marriage, first sexual experience and child bearing may take place for many in different personal and social contexts. Because of the inequity between sexes that pervades all societies, adolescent girls are particularly vulnerable to the risks associated with misinformed and unprotected sexual relationships and the hazards of teenage pregnancies.

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# A. Demographic Profile of Adolescents

## 1. How large is the adolescent population?

- **According to World Health Organization statistics, in 1995 50% of the world's population were below the age of 25, and one-fifth of the world's population were adolescents. Of the world's 1.1 billion adolescents, 913 million live in developing countries and 160 million in developed countries.[2] This will be the largest generation in history to make the transition from children to adults. The sheer size of the group commands attention.**

**Table 1**

**ADOLESCENTS IN THE WORLD POPULATION Estimated Populations for 1995 and Projected Populations for 2010, World and Regions**

| Region | 1995 Age group 10-19 as % of total population | 2010 Age group 10-19 as % of total population | % Increase |
|---|---|---|---|
| World | 19 | 18 | 17 |
| Developed Regions | 14 | 12 | -9 |
| Developing Regions (including China) | 20 | 19 | 21 |
| Sub-Saharan Africa | 23 | 24 | 55 |
| Northern Africa | 23 | 20 | 19 |
| East Asia | 16 | 15 | 3 |
| South-Central Asia | 21 | 20 | 24 |
| Southeastern Asia | 21 | 19 | 12 |
| Western Asia | 21 | 21 | 37 |
| Europe | 14 | 11 | -17 |
| North America | 14 | 14 | 15 |
| Latin America & Caribbean | 21 | 18 | 10 |
| Oceania | 17 | 14 | – |

**Source:** Population Reports, Series L No. 41, October 1995. The Johns Hopkins School of Public Health. Table 1, p. 4



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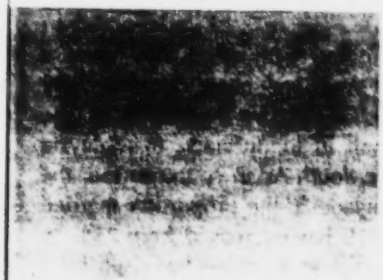
- **The Asia-Pacific region accounts for about 60% world's population, of which one-fifth are adolescents. Overall, these numbers will increase in the next couple of decades before a decline begins.[3] The world's two most populous countries, China and India, were each home to approximately 200 million young people.**
- **The absolute numbers of adolescents do not increase significantly, or actually decline, with the exception of the South and South-West Asia sub-region.**
- **The percentage share of adolescents in the population will generally decline after the year 2000.**
- **Over half of adolescents within the Asia-Pacific region will be in South and South-West Asia.**

**Table 3**

**Percentage of Married Women Aged 20-24, by Age by which Married and Median Age at First Marriage in Selected Countries in the Asia-Pacific Region**

| Sub-region | 1995 | 2000 | 2010 | 2020 |
|---|---|---|---|---|
| East and North-East Asia | 227,178 (16.0) | 243,473 (16.4) | 224,452 (14.2) | 204,664 (12.3) |
| South-East Asia | 103, 156 (21.4) | 107,669 (20.7) | 111,433 (18.8) | 108,074 (16.4) |
| South and South-West Asia | 296,435 (21.6) | 327,730 (21.8) | 341,730 (19.4) | 358,048 (17.9) |
| North and Central Asia | 36,097 (16.9) | 38,449 (17.9) | 29,408 (13.4) | 29,604 (13.3) |
| Pacific | 4,418 (15.6) | 4,658 (15.4) | 5,186 (15.1) | 5,521 (14.3) |
| ESCAP | 667,284 (19.0) | 721,893 (19.2) | 712,209 (17.0) | 705,911 (15.4) |

**Source:** Suman Mehta, Riet Groenen, and Francisco Roque, "Implementation Challenges of Reproductive Health, Including Family Planning and Sexual Health: Adolescent Reproductive Health". Paper prepared for a meeting of ESCAP and UNFPA, Bangkok, 24-27 March, 1998. POP/ICPD/5. Table 1, p. 4.



## 2. At what age do they get married?

- **In most of the Asia-Pacific countries, age at marriage during adolescent years is quite varied.**

In Bangladesh for example, almost three-fourths of women marry before age 18, while in the Philippines and Sri Lanka, only 14% do so. In China, where the government has set a strict minimum age for marriage, only 5% of women wed before age 18.[4] Marriage determines the onset of sexual activity, especially for women. Therefore, age at marriage is a major determinant of reproductive health.



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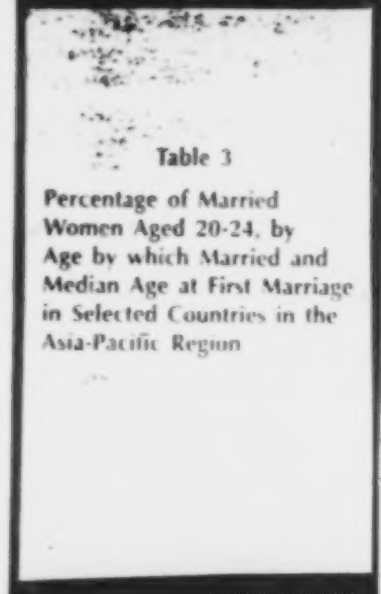

**Table 3**

**Percentage of Married Women Aged 20-24, by Age by which Married and Median Age at First Marriage in Selected Countries in the Asia-Pacific Region**

- **Generally, age at marriage is considerably lower for women than for men.**

In Bangladesh, for example, 8% of boys as compared to 76% of girls were married in the age group 15-19.[5]

| Country | By Age 15 (%) | By Age 18 (%) | By Age 20 (%) | Median Age at First Marriage |
|---|---|---|---|---|
| Bangladesh (1993-1994) | 47 | 73 | 82 | 14.1 |
| India (1992-1993) | 26 | 54 | 71 | 16.1 |
| Indonesia (1994) | 9 | 31 | 48 | 17.7 |
| Japan (1992) | 0 | 0 | 2 | 26.4 |
| Nepal (1996) | 19 | 60 | 76 | – |
| Philippines (1993) | 2 | 14 | 29 | 21.4 |
| Sri Lanka (1993) | 1 | 12 | 24 | 22.4 |
| Thailand (1987) | 2 | 20 | 37 | 20.5 |
| Vietnam (1998) | 1 | 9 | 31 | – |

**Source:** 1. Suman Mehta, Riet Groenen, and Francisco Roque, "Implementation Challenges of Reproductive Health, Including Family Planning and Sexual Health: Adolescent Reproductive Health". Paper prepared for a meeting of ESCAP an UNFPA, 24-27 March 1998. POP/ICPD/5. Table 2, p. 5.

2. De Silva, W. "Socio- cultural Factors, Changing Marriage Patterns and Policies Affecting Adolescents and Youth, including their Reproductive Health". Paper prepared for ESCAP Expert Group Meeting on Adolescent. Bangkok, 30 Sept.-2 Oct. 1997.

- **The age at marriage is increasing in most countries of the Asia-Pacific region. This has resulted in extended period of adolescence. This in turn has raised a whole set of new issues, including management of sexuality during the period of premarital sexual activity.**

Overall, marriage during adolescence is less common than it was a generation ago. Compared with what they were a generation ago, levels of early marriage have decreased by one-quarter in Bangladesh and India, by one-third in the Philippines, and by about one-half in Indonesia.[6] In Malaysia there has been a sharp decline; in South Asian countries too, the age at marriage is rising. In Bangladesh, the proportion married among girls in the age group 15-19 has decreased from 75% in 1974 to 51% in 1991.[7] Female age at marriage has risen by a greater margin than male ages at marriage, leading to a narrowing of age difference between the spouses.



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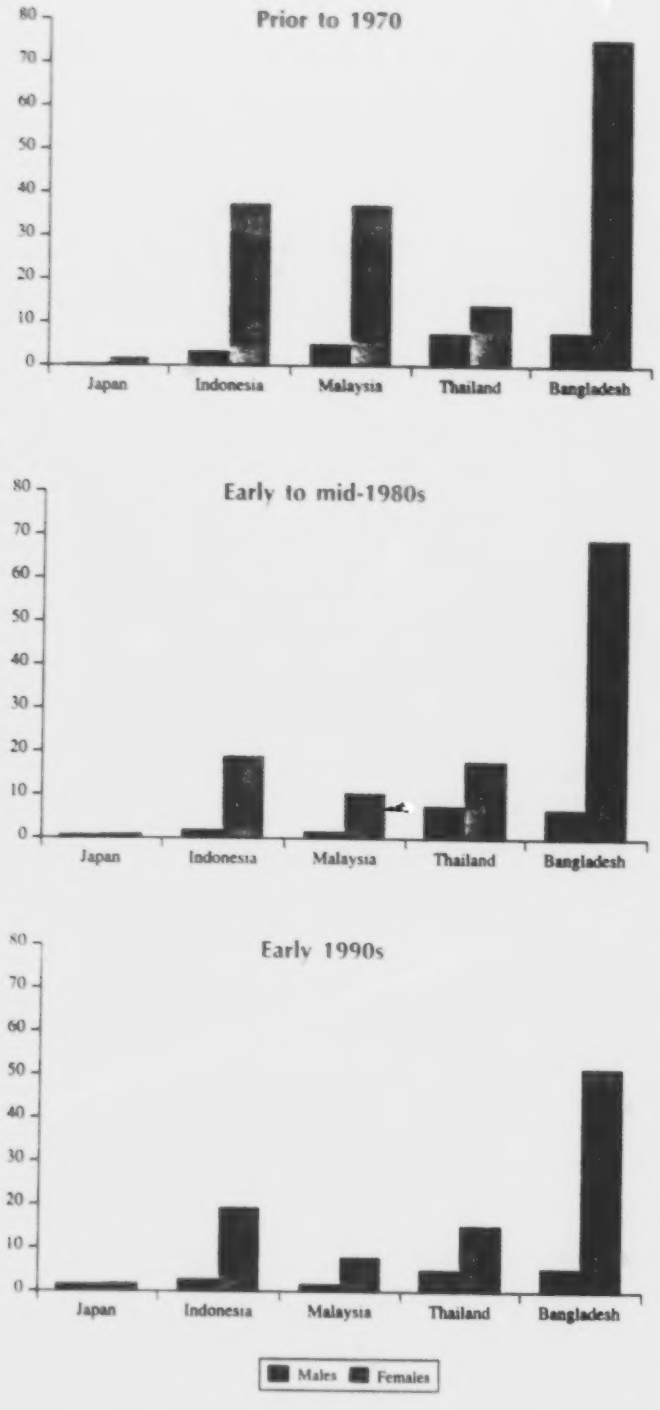
**Chart 1**

**Proportion of Ever Married Aged 15-19, Selected Countries and Years**




**Source:** ESCAP, Asian Population Studies Series 149, Fig. II, p. 27: Proportion ever married aged 15-19.



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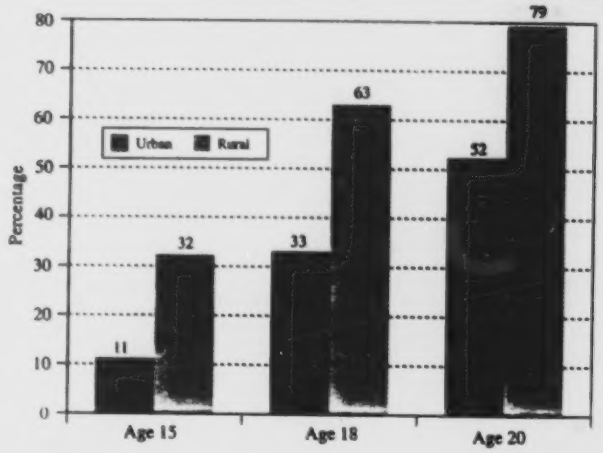
- **Among eight Asian countries with recent data, it was found that in the age group 40-44, 57% of women had married by age of 20. However, only 37% of women currently in the age group 20-24 were married.[8]**
- **In Latin America and the Caribbean, the proportion married by age 20 has remained comparatively stable, declining only from 50% to 42%. In Western Europe and Northern America, the age at marriage has been rising steadily, from early to middle to late twenties.[9]**
- **The age at marriage is influenced by education, urbanization, employment opportunities, and communication outreach.**

In India for example, 80% of rural women in the 20-24 age group were married by age 20; in urban areas, this proportion was 50%.[10]

**Chart 2**

**Percentage of Women Aged 20-24 Married by Exact Ages 15, 18 and 20, By Residence: India, 1992-1993.**




Source: ESCAP, Asian Population Studies Series No. 149, UN., Fig. II, p. 58.

## 3. What is the educational attainment of adolescents?

- **Primary level schooling is compulsory in all the countries, yet not every child is enrolled, and many do not complete it.**

In South Asia, for example, over 96% of children enrol in grade 1 of primary school, but only 50% reach grade 5. A significantly larger proportion of children in South-East Asian countries reach grade 5, but the estimates are certainly below the record of Japan and the Republic of Korea. Also, in Indonesia, 20% of children do not complete primary education and in Bangladesh less than 50% reach grade 4.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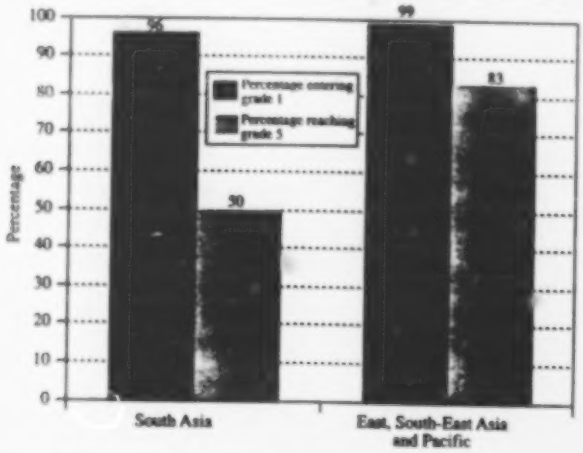
- **Poverty, remoteness, gender, intra-family age-sex composition, ethnicity and religion are the key factors that determine different access and retention of education during adolescence.**

**Chart 3**

**Percentage of Children Entering Grade 1 and Percentage Reaching Grade 5, 1988-1990**




**Source:** ESCAP, Asian Population Studies Series No. 149 , Fig. I, p. 51.

- **A higher level of education is usually found to be associated with a later age at marriage. Generally, less educated women are more likely to marry early.**

In India, among women aged 25-29, the median age at marriage is 15 for illiterate women and 22 for women who have completed high school.[11]

- **Both school attendance and school enrolment is considerably lower for girls than boys in many countries.**

The gender gap is wider in South Asian countries, excepting Sri Lanka, and in many African countries. This situation reflects the lower status of women in many societies.

- **Studies show that attendance at school of girls is more affected than that of boys by such factors as distance to the school, the number of children in the household, and restrictions on mobility.**

Tasks performed by girls, typically relating to household work including sibling care, interfere more with education. Parents may also feel that any gain in productivity or income owing to education will accrue to the family into which the daughter marries rather than to themselves.

- **Secondary school enrolment of boys far outnumber those of girls in many countries.**



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| Country | Percentage of women aged 20-24, married before age 20, who had completed primary school | Percentage of women aged 20-24, married at age 20 or later, who had completed primary school |
|---|---|---|
| Zambia | 44 | 83 |
| Uganda | 20 | 43 |
| Kenya | 54 | 84 |
| Cameroon | 27 | 77 |
| Indonesia | 18 | 58 |
| Philippines | 61 | 84 |
| Colombia | 39 | 66 |
| Mexico | 32 | 72 |
| Egypt | 25 | 60 |

**Source:** Compiled from United Nations Population Fund. The State of the World Population 1997. UNFPA. p. 39.

**Table 5**

**Gender Difference in Secondary School Enrolment (1990-1994)**

| Region/country | Secondary School Enrolment Rate (gross) | Secondary School Enrolment Rate (gross) |
|---|---|---|
| | Male | Female |
| **East Asia** | | |
| China | 60 | 51 |
| Japan | 95 | 97 |
| Republic of Korea | 97 | 96 |
| **South-East Asia** | | |
| Indonesia | 48 | 39 |
| Philippines | 64 | 65 |
| Thailand | 38 | 37 |
| **South Asia** | | |
| Bangladesh | 25 | 13 |
| India | 59 | 38 |
| Sri Lanka | 71 | 78 |
| **Central Asia** | | |
| Armenia | 80 | 90 |
| Azerbaijan | – | – |
| Uzbekistan | 96 | 92 |
| **Oceania and Pacific** | | |
| Australia | 83 | 86 |
| Fiji | – | – |
| Tonga | – | – |

**Source:** Economic and Social Commission for Asia and the Pacific. Asian Population Studies Series 149. New York: United Nations, 1998. Table 2, p. 51.



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## 4. What is the general health status of adolescents?

- **Adolescence is the only period in which growth accelerates. The growth depends on nutrition which in turn depends on availability of food of sufficient quantity and quality and on prevalence of diseases and metabolism.**

- **Adolescents' nutritional status could also be related to gender discrimination. In many countries, girls receive less and lower quality food.**

Moreover, in some Asian countries the food consumption of girls may be limited for fear that they will grow more rapidly, which will bring more pressure on the parents to arrange an early marriage and get together a dowry.

- **A large increase in nutrients is required during adolescence, especially iron requirement among adolescent girls. Because of menstrual blood loss, girls have 10% less iron than boys and are more likely to be anaemic.[12]**

In many areas, an adolescent girl's food intake is more likely to be inadequate in all nutrients. According to a study carried out in 1992/93, by the International Centre for Research on Women, as much as 42 and 55% of adolescent girls are found to be anaemic in Nepal and India.[13]

Malnutrition can result in stunted growth in adolescents. Studies indicate that in some South-Asian countries, the percentage of stunting among adolescent females was significantly higher than among adolescent males. For example, in India the percentages are 45 and 20.[14]

- **Many adolescents in the region marry before reaching full physical maturity which leads to reproductive health problems and affects survival chances of their offspring.**

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# B. Fertility, Teen Pregnancy and Abortion

## 1. Fertility

- **Almost 15 million births worldwide, are to young mothers.[15] The majority of young women in the developing world still have their first child within marriage. Therefore the median age at first birth still closely follows the median age at marriage.**

In counties where most women still marry young, fertility rates among 15-19 age group remain high – reaching close to 200 per 1,000 women in some Sub-Saharan countries like Mali and Niger.[16]

**Table 6**

**Age-specific Fertility (15-19 years) in Selected Countries of the ESCAP Region**

| Country | Births per 1,000 Women |
|---|---|
| Cambodia | 23 |
| China | 5 |
| Democratic Republic of Korea | 5 |
| Indonesia | 45 |
| Lao People's Democratic Republic | 51 |
| Malaysia | 29 |
| Mongolia | 38 |
| Myanmar | 36 |
| Philippines | 41 |
| Republic of Korea | 4 |
| Singapore | 8 |
| Thailand | 60 |
| Vietnam | 35 |

**Source:** 1. Suman Mehta, Riet Groenen, and Francisco Roque, "Implementation challenges of reproductive health, Including Family Planning and Sexual Health: Adolescent Reproductive Health", Paper prepared for a meeting of ESCAP and UNFPA. POP/ICPD/%, Bangkok, 21-24 March 1998. Table 4, p. 11.

2. ESCAP Population Data Sheet, Bangkok, 1997.

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About 35% of young women in Latin America and the Caribbean have their first child before their 20th birthday, and 50-60% do so in most countries in sub-Saharan Africa. In the United States, 19% of young women give birth before age 20 – one of the highest levels of adolescent child bearing in the developed world.[17]

- **Overall fertility varies considerably between countries of Asia and the Pacific.**

In the ESCAP region, age-specific fertility rates are lowest in East Asia, with 4-5 births per 1,000 women in 15-19 age group, and highest in South-Asia, ranging from 71-119. For example, there is a higher proportion of young women giving birth below 20 years in Indonesia and Pakistan where age at marriage is fairly low, than in Sri Lanka or Thailand, where it is higher.

- **As age at marriage rose during the late 1970s and 1980s, fertility rates among women under age 20 declined in many countries.**

In Bangladesh, age-specific fertility rate declined from 219 per 1,000 aged 15-19 in 1970 to 140 in 1990. In Indonesia there was a 50% decline in the same period.[18]

- **While the age-specific fertility in most countries have declined over the years, it is questionable whether the risk of teenage pregnancies, which is a better indicator of the fertility status has decreased.**

## 2. Teen pregnancy and early childbearing

- **Globally, an estimated 15 million teenage women give birth each year which accounts for one-fifth of all births.[19]**

- **In many parts of the world, women have their first child early, often before age 18.[20]**

Having a baby before age 15 is rare; generally, fewer than 3% of women in developing countries give birth by this age. In most Asian countries, fewer than 20% of women have their first birth before age 18, although about 30% in India and almost 50% in Bangladesh do.

- **Adolescent childbearing is declining in countries where it has been common.**

In Asia, young women are less likely than women of their mother's generation to have their first child during adolescence. In Bangladesh, India, Pakistan, the Philippines and Thailand, levels of adolescent childbearing among women aged 20-24 are about 80% of those found among women 40-44, while in China, Indonesia, Sri Lanka and Turkey, levels are one-half to two-thirds those of the previous generation.[21]



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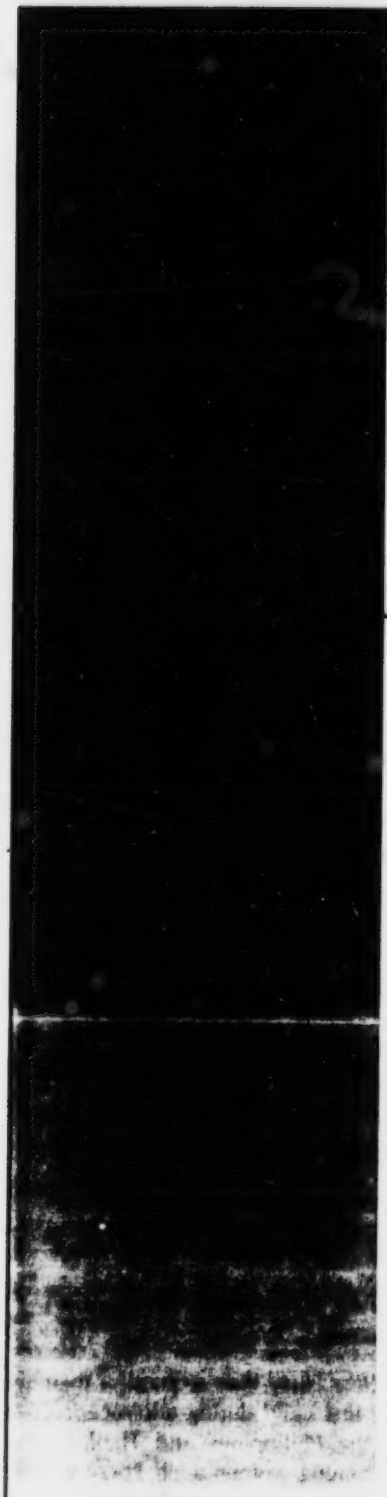
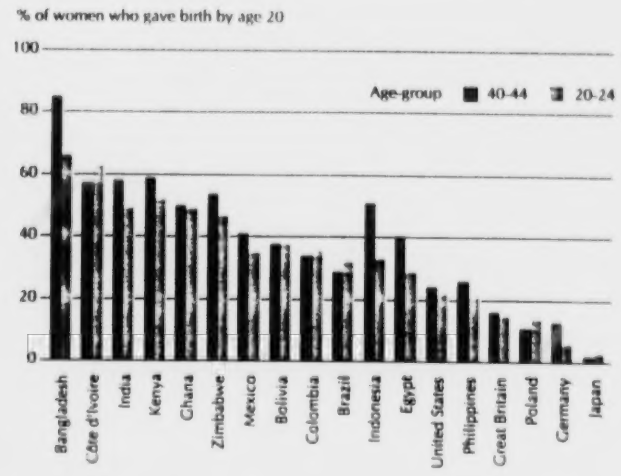





**Source:** The Alan Guttmacher Institute. Into a new world: young women's sexual and reproductive lives. New York, 1998. p. 25.

- **Pregnancy in adolescence has serious health consequences. The risk of maternal death among pregnant women in the age group 15-19 is four times higher than among 25-29 year olds. Early pregnancy can lead to serious health complications with long-term consequences.[22]**

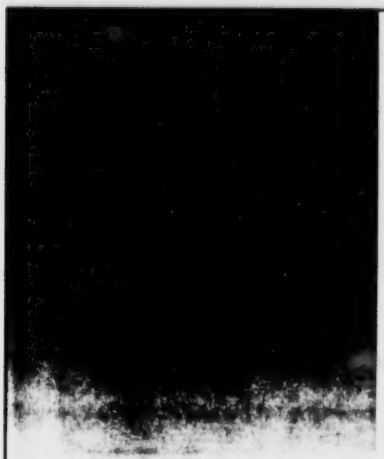
A World Health Organization study in 1995 reports that in several countries, including Bangladesh, Indonesia and Egypt, 26-37% of deaths among female adolescents can be attributed to pregnancy and childbirth. In Bangladesh, the excess of female deaths as compared to males in the age group 15-24 can be attributed to maternal mortality.[23] Maternal mortality rate in Bangladesh among 15-19 year olds was about five times higher than that of 20-24 age group.

- **Early childbearing can limit educational attainment, restrict the skills young people bring to the work force and reduce their quality of life.**

## 3. Abortion

- **In most countries in East and South-East Asia, abortion on request or on broad social grounds are not available legally. Yet, the number of adolescent women in developing countries having an abortion annually has been estimated to be between 1 and 4.4 million.[24]**

Pre-marital pregnancy is socially and culturally unacceptable in many countries. Often, abortion is the likely outcome.



A study from Vietnam shows that only one-fourth of women aged 15-24 who underwent an abortion confided in a friend, and only 13% in a family member. In some African countries adolescents account for 74% of all induced abortions. In India, 30% of all hospital abortions are performed on women under 20.[25] Thailand has a high percentage of teenage pregnancies and abortion, with some 300,000 abortions taking place every year or one in every three live births.

- **Adolescents are more likely to hide the pregnancy, seek abortion relatively late, and accept it being performed under clandestine and unsafe conditions by untrained providers. They are at a higher risk of serious complications such as hemorrhage, septicemia, injuries and infertility.**

# C. Sexual Behaviour Among Adolescents, Age at First Intercourse, Incidence of Pre-marital Sexual Activity

- **The proportion of adolescents who are sexually active before age 16 is steadily rising in industrial countries.**

As young people postpone marriage to later ages, the likelihood of beginning a sexual relationship prior to marriage increases in both developed and developing countries. In United Kingdom, among respondents under age 20, 18.7% of women and 27.6% of men reported first intercourse before age 16. Whereas, less than 2% of women and 10% of men now over 50 reported the same.[26] In many industrialized countries, sexual activity starts in middle to late teens and age at marriage is relatively late. Some have high rates of adolescent pregnancy, and increasing numbers of young, unmarried mothers raising children alone.[27]

- **In most sub-Saharan African countries, 40% or more of 20-24 year old women have sexual intercourse prior to their first marriage and before they are 20.[28]**

Traditionally, in some parts of sub-Saharan Africa, premarital sexual relationships are encouraged because young women are expected to prove their fecundity prior to marriage.

- **In Latin America and the Caribbean the proportion of women, both married and unmarried who are sexually active before age 20 appears to have either fallen or remained stable in most countries. Households headed by young single mothers have increased.**

- **In some countries in Africa, such as Burundi, Ghana, Kenya and Zimbabwe, sexual activity before age 16 may have declined.[29]**

- **Some studies indicate that sexual initiation of girls often occurs even before menarche.**

In Malawi, in a sample of 300 adolescent girls, 58% had sex before menarche.[30]



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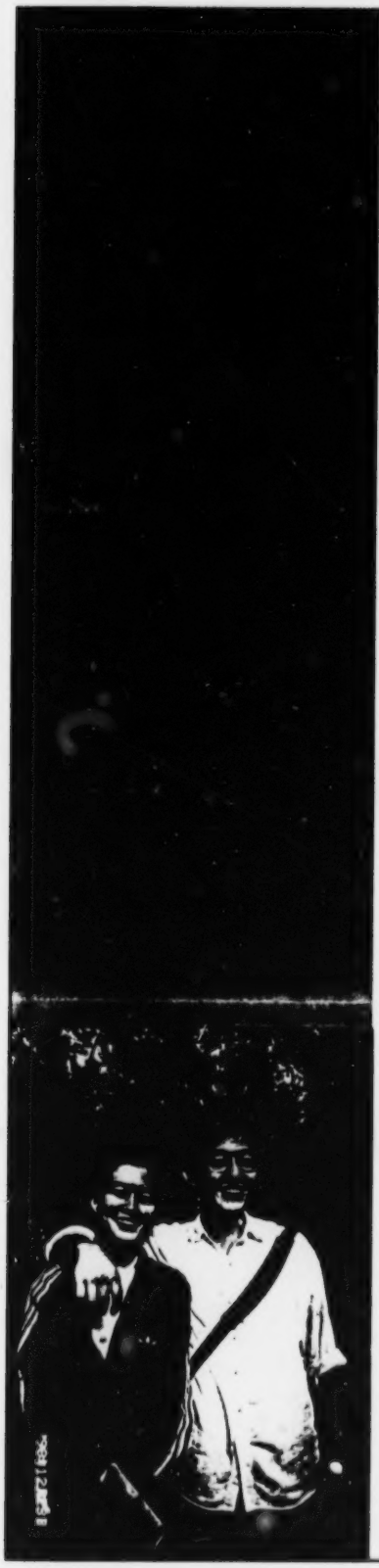

- **Sexual activity begins in early adolescence for many in the Asia-Pacific region. In particular, a number of studies showed that a significant proportion of male adolescents are sexually experienced. In general, the onset of sexual activity in South Asia occurs largely within the context of marriage.**

Sexual relations prior to marriage is on the rise in Asia and the Pacific though more and more young men and women are delaying marriage. Country-specific studies conducted by WHO in Asia showed increasing sexual activity among young people in the region.

A study on sexual behaviour in rural Thailand obtained from 582 males and 526 females who had never been married as well as 41 males and 79 females who had been married showed that among the respondents who had never been married, there was considerable difference between males and females in the reporting of sexual experience. As many as half of the males (37% of the 15-19-year olds and 79% of the 20-24 year olds) reported they had had sexual intercourse, while only 2% of the never-married females reported this. The average age at first sexual intercourse was 16.6 years for males and 17.6 years for females.[31]

A further study investigating sexual behaviour in young factory workers showed that of the 601 male respondents, 81% had sexual experience and over half of these had their first sexual experience when they were aged 16-18 years. Nearly half of those who were sexually experienced had their first sexual intercourse with a prostitute. Of the 609 female respondents, 42% had sexual experience and for this group the age at first sexual intercourse was spread fairly evenly through the age range 16-24 years. These studies in Thailand conclude that the average age at first sex encounter is between 16-18 years.[32]

A study of Philippines in 1993 shows that the reported sexual contacts among never-married women aged 15-19 and 20-24 were 0.4 and 2.1% only; while 13 and 20% of the ever-married youth of the same age groups respectively reported a premarital sexual experience.[33]

A study in Malaysia conducted in 1994 and 1995, shows that 23% of 13-19 year olds reported to be sexually active and 40% of the respondents began dating between 13 to 15 years of age.[34] A survey in Cambodia in 1996 reported the prevalence of sexual activities among teen-agers was low – 40% of the 1,006 respondents stated that they ever had sex.[35] In Mongolia, a survey reports that of the 4,674 adolescents surveyed, 30.6% have entered into a sexual relationship.[36]

Premarital sexual activity in South-Asian countries is uncommon. A study of 15-19 age group in India, 16% of men



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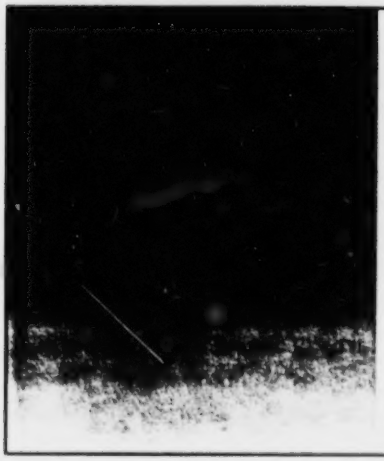
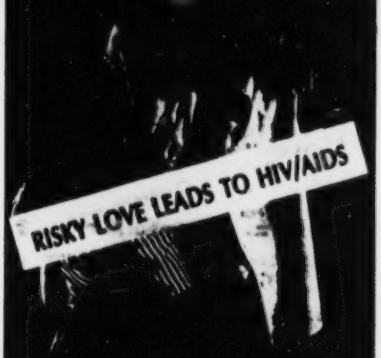


and 33% of women reported to be sexually active. The average age at first sexual encounter was 16 years for men and 18 years for women.[37]

The median age at first intercourse among women has increased in many countries. Continued education and delayed marriage may account for some of it. While first intercourse tends to occur at a later age than in the past, it increasingly occurs before marriage. Even where age at first intercourse is rising, age at marriage is rising faster.[38]

**It is believed that there may have been substantial under reporting of sexual experience by never married teenagers in Asia.**

# D. STD, HIV/ AIDS Incidence




- **Young people form a high risk group for susceptibility for STD infection. It is estimated that about 50% of HIV infection is among people of 15-24 age group and many contact the infection before they are 20.**[39]

Those who become sexually active early, and change partners frequently are at greater risk. Young women are more at risk due to biological factors and greater vulnerability to sexual abuse.

- **A large number of adolescent girls work as prostitutes.**

In Thailand it is estimated that 800,000 sex workers are below 20, and 200,000 are below 14 year of age. Many are forced into prostitution, are ignorant of reproductive health related issues, have little power to negotiate condom use with their clients, and have little access to reproductive health services.[40]

Although it is an issue of great importance, yet accurate data are not available for most countries. There are no surveys to indicate the prevalence of STD among different sub-populations or how the pattern is changing over time. Most of the information are about commercial sex workers. In a study in 1992 among 450 sex workers in Calcutta, it was found that only 1% used condoms on a regular basis. In this group, STD prevalence was 80% and HIV prevalence 1%.[41] HIV prevalence is better documented, although data are rarely age-specific or sub-group specific. The issues of STD and AIDS are linked, and special strategy is needed to tackle the problems.

- **According to WHO estimates, one in 20 adolescents and young people contracts an STD each year and the trend is increasing.**

- Adolescents are at high risk of contracting an STD because **they tend to engage in short-term sexual relationships and do not use condoms consistently to protect themselves from infection.**

In many cultures, men are encouraged to express their masculinity by being sexually active at a young age, often initiated by prostitutes, or older women.

- **Cultural factors also make young people vulnerable to STDs.**

In some societies, social pressures and norms expect the sexual initiation of boys by entering into sexual contacts with commercial sex workers. In some cultures where young women are paired with older men, the possibility of getting infected is more likely because older men have had more partners and young women – wives and girlfriends, are less able to negotiate condom use. Many cultures equate ignorance in women with innocence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and sexual purity. Therefore young women frequently lack the information they need to identify STD symptoms.

- **The likelihood of HIV transmission is greater if one partner has an STD. Women are more likely than men to have untreated STD because many STDs do not cause symptoms in women.**

Moreover, HIV transmission is more efficient from men to women than from women to men. Teenagers exposed to HIV face a greater risk of infection due to physical immaturity of their reproductive system.

- **WHO reports that the highest rates of STDs occur among 20-24 year olds, followed by teens aged 15-19.**
- **Nearly 25 million people have been affected with HIV, and young people under age 25 account for one-half of all HIV infections.**
- **WHO research reveals that HIV is spreading rapidly among young women aged 15-24. In many countries, they account for 40% of all new HIV infections. On average, women are being infected with HIV at ages 5-10 years younger than men.[42]**

# E. Use of Family Planning Services and Contraception

- **In the Asia-Pacific region, contraceptive use among adolescents is very low in India and Pakistan (7% and 5% respectively) but more common in Indonesia and Thailand (36% and 43% respectively).[41]**

In the Marshall Islands, among 15-19 year olds, the contraceptive prevalence rate was 11% in 1994. A survey carried out in the Marshall Islands, Fiji and Western Samoa show that 58% of the respondents had ever used a condom. Access to reproductive health sources for young people is constrained.[44]

- **Young people know of modern methods but may lack access or information on proper use. Often there are legal and/or social restrictions to the provision of contraceptive services to unmarried adolescents.**

In most countries of Asia, Latin America, the Caribbean, North Africa and the Middle East, more than 60% of adolescent women report that they have heard of at least one modern contraceptive methods (Chart 6) Even if young people know about birth control methods, they may not know where to obtain them. Most data on contraceptive use are collected for married adolescents. Recent data indicate that use of contraceptives is low among adolescent women as compared to older women. Data on contraceptive use are mainly available for married adolescents.

Table 7

**Contraceptive Knowledge and Current Use among Women aged 15-19**

| Country | Knowledge of any method | Knowledge of three or more methods | Current use, any method |
|---|---|---|---|
| Bangladesh 1993/94 | 99.5 | 98.0 | 24.7 |
| India 1992/93 | 90.4 | 65.5 | 7.1 |
| Indonesia 1994 | 97.0 | 85.8 | 36.4 |
| Philippines 1993 | 89.6 | 85.2 | 17.2 |
| Sri Lanka 1993 | 96.3 | – | 30.3 |

**Source:** Economic and Social Commission for Asia and the Pacific, Asian Population Studies Series No. 149, Table 7, p. 67.



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**Table 8**

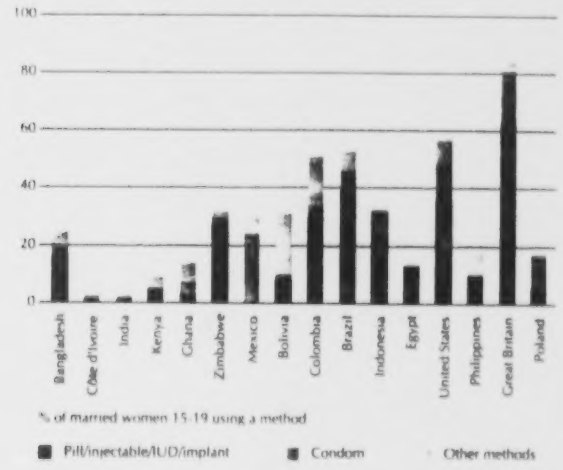
**Contraceptive Prevalence among Adolescents Aged 15-19**

| Country | Contraceptive Prevalence |
|---|---|
| Cambodia | 2.6 |
| China | 11 |
| Democratic Republic of Korea | - |
| Hong Kong,China | - |
| Indonesia | 25.5 |
| Lao People's Democratic Republic | - |
| Myanmar | 17.2 |

**Source:** Khan, A.R. and Francisco Roque, "Adolescent Reproductive Health and Sexuality Education: Needs, Issues and Approaches" Paper prepared for consultative meeting of UNFPA, CST and Programme Officers, Bangkok, 21-24 August 1996. Table 1, p. 4.

**Chart 5**

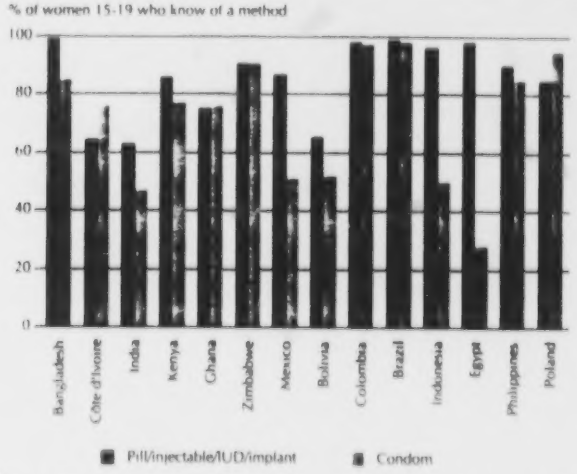
**In some countries, few married adolescent women practice contraception**




**Source:** The Alan Guttmacher Institute, Into a new world: young women's sexual and reproductive lives. New York, 1998. p. 27.

**Chart 6**

**The majority of young women know about modern contraceptive methods**




**Source:** The Alan Guttmacher Institute, Into a new world: young women's sexual and reproductive lives. New York, 1998. p. 29.



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# SECTION TWO: FACTORS AND PROBLEMS ASSOCIATED WITH ADOLESCENT REPRODUCTIVE AND SEXUAL HEALTH

## A. Effects of early marriage and early and frequent pregnancy and childbearing and teen abortion

### 1. Some causes of higher levels of maternal mortality and morbidity among adolescents:

- ***Adolescents are more prone to certain complications than older women and are more likely to suffer from prolonged and obstructed labour because their pelvic growth is incomplete.***

In Bangladesh, a study shows that deaths from hypertensive disorders of pregnancy and abortion are much higher among teenagers than among women in 20-34 age group.

- ***Adolescents are less likely to avail of antenatal or delivery care for a variety of reasons. Therefore they run a higher risk of death.***

- ***Adolescents are more likely to be unmarried and therefore may lack family and social support in many countries where pre-marital pregnancy is unacceptable, and are at increased risk of mortality.***

Maternal mortality among adolescents in developing countries is estimated to be 80% to 5 times higher as compared to maternal mortality in general.[45] Girls aged 10-14 in rural Bangladesh were found to have rates of 1,170 maternal deaths per 100,000 live births, compared to 740 for those aged 15-19 and 484 for those aged 20-34.[46]

- ***The immense emotional, social and financial consequences of unwanted pregnancy may force a teenager to have an abortion.***

- ***The reach of health services is grossly inadequate in most developing countries, and abortion which is illegal in many is performed under circumstances involving severe health risks and the possibility of permanent disability or even death is high.***

- ***Childbearing in adolescence is most common among the poor. As these young mothers may be malnourished, this may contribute to poor pregnancy outcomes.***

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## 2. Emotional, social and financial consequences of early childbearing:

- ***Early pregnancy subjects young women to tensions, difficulties and pressures, especially if she is unmarried.***

When the pregnant girl is unmarried, she fears the reaction of parents, relatives, neighbours and friends. Fear of rejection by the family causes emotional and psychological problems.

- ***Another negative effect is the likely loss of opportunities for further schooling.***

Family pressure and/or economic pressure often forces pregnant teenagers to drop out of school. Some schools in Asia and Africa expel pregnant teenagers as a matter of policy.

A study in Nigeria showed that 52% of pregnant adolescents were expelled from school.[47]

- ***Pregnancy often forces teenagers from the poorer sections of society to take on low-paid jobs or work involving health risks to survive.***

Lack of education and skill limit job opportunities. Many enter the sex trade, where they are vulnerable to STD, HIV, sexual abuse and violence.

## 3. Children of Adolescents:

- ***Unwanted pregnancy leads to abandonment of children and the growing phenomenon of street children.***

In Brazil alone, there are about 200,000 street children who face a bleak future.[48] This sets up a vicious circle of girls entering the sex trade for survival, unwanted pregnancies and abandoned children.

- ***Adolescent births involve a higher risk of low birth weight and prematurity, stillbirths and neonatal deaths.***

The risk of dying in the first year of life is typically greater by 30% or more among babies whose mothers are aged 15-19, than among those born to mothers aged 20-29.[49]

Based on 25 DHS data, it was concluded that children born to mothers aged below 18 years are subject to, on average, 46% higher risk of mortality.[50]

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- ***Worldwide, young adults and children suffer the physical and emotional traumas of sexual assault and rape.***

Because much sexual violence goes unreported, it is difficult to estimate how many young people suffer from sexual abuse, sexual coercion, incest or violence. Most often the perpetrators are relatives, neighbours or acquaintances.

- ***Among women in the United States, 74% of those who experienced intercourse before age 14 and 60% of those who experienced sex before age 15, reported having been forced.***[51]

Many adolescent women are sexually assaulted by their boyfriends or dates. Adolescent women in traditional societies, married to much older men, are often unable to negotiate or control the frequency or the timings of intercourse, and are often coerced by their husbands.

- ***In many parts of the world, youths are victims of sexual exploitation for commercial gain.***

According to UNICEF, sexual exploitation of children and adolescents is a multibillion-dollar illegal industry. In Bangladesh, Nepal, the Philippines and Thailand, youths have been lured into prostitution by recruiters; or parents may sell their daughters into prostitution as source of income or daughters may choose this route to fulfill an economic obligation.

- ***Sexual abuse in childhood can lead to high risk behavior later in life.***

Young people who are sexually abused in childhood start consensual sexual activity early, are more likely to use drugs and alcohol, and are less likely to use contraceptives. Sexual violence can lead to severe injuries, mental illness, alcohol abuse, drug abuse, sexual dysfunction, unwanted pregnancy, STD and HIV. It may lead to attempted suicide.

- ***In all cultures the rape victim is suspected of collusion with the rapist.***

Since the victims are traumatized and stigmatized by the experience, only a small proportion of rapes are reported, especially when the perpetrator is a family member or a friend of the family. Reports of rape do not guarantee redress or punishment of the offenders.

- ***It is difficult to prove sexual violence, unless there is clear physical injury.***

# SECTION THREE: CAUSES OF UNHEALTHY DEVELOPMENT OF ADOLESCENTS

## Early marriage

- **Early marriage results in too-early pregnancy. Pregnant women younger than 15 years are 4-8 times more likely to die during pregnancy and childbirth.**

Early motherhood results in inadequate growth, undernutrition, hypertension, and anaemia. Motherhood imposed on an immature body, can result in prolonged and obstructed labour, and lifelong health problems. Adolescent women married to much older men are unable to communicate or negotiate the timing and frequency of intercourse, and contraceptive use with their husbands and therefore unable to control their own fertility.

## Lack of access to family planning facilities

- **To a vast majority of adolescents in the developing world, family planning information and services are not accessible.**
- **In many countries the existing policies do not permit the provision of information and/or family planning services to unmarried adolescents.**

Even when there is no restrictive legislation, due to cultural and religious taboos, health workers refuse to provide contraceptive services and information to unmarried adolescents. Sometimes health workers insist on parental consent to provide such care.

Often, there is socio-cultural resistance to the provision of adolescent reproductive health related information/services from various groups, or from some sections of the society. Sexual education for youth is hampered by adults who believe that it will encourage promiscuity. Parents and elders in the family do not like to talk about or offer advice on reproductive health-related issues to an adolescent.

- **There may be physical barriers to services, in terms of location, service hours, and privacy, and financial barriers to access these services. Information may be unavailable, or inappropriate, too technical, or not well targeted.**

- **Reproductive health services are often not well-linked to other general health services.**

The family planning clinics may be located separately or clearly separated from the general health care unit. This makes it difficult for young women, if they are unmarried, to visit the clinic. Family planning information and contraceptives are not routinely available in primary health care centres, especially where adolescents are concerned.

Adolescent men are even less likely to receive family planning services, since reproduction is not perceived as male responsibility.

- **Eligibility for family planning services is often defined in terms of couples, rather than in terms of individuals.**

## Lack of medical care at childbirth

- **For millions of adolescent women across the world, skilled medical care is not available at childbirth.**

Women living in rural areas often do not have medical care services within reach. They have to travel long distances to reach maternity clinics for prenatal examination.

- **Ignorance, lack of concern among other members of the family, social taboos, lack of ready cash to pay for travel expenses, prevent them from seeking medical examination.**

Consequently, pregnancies at risk are not identified. Prenatal examination and observation can easily identify such cases and prevent maternal deaths. Transport for women in labour is particularly difficult and life-threatening.

- **When childbearing starts too early in a girl's life, pregnancy-related complications such as obstructed labour are more likely.**

Over and above this, if the mother is malnourished and anaemic, the outcome can be tragic for both mother and child and lead to permanent damage to health if skilled medical care is not available.

## Genital mutilation

- **Female genital mutilation, or female circumcision, is practiced in as many as 28 African countries, and a few countries outside Africa.**[52]

The percentage of women subjected to genital mutilation is as high as 98% in Somalia and Djibuti.

The practice may reflect deeply held cultural beliefs. Nonetheless, it constitutes violence against women and even more so against children on whom it is practiced without their consent.

- **Female genital mutilation is painful, dangerous, traumatic and life-threatening.**

The physical consequences of FGM include infection, pain induced shock, damage to the organs, painful intercourse, obstructed labour, and higher risk of STD infection.

## Poverty

- **As income varies widely within a country, so do the conditions of everyday life. As a result, some impoverished families may sacrifice their child's education for the labour required from the child to help provide for the family.**

Poverty is characterized by lack of adequate housing, transportation, electricity, access to safe water and sanitation services which in turn make life's daily work extremely burdensome. This results in poor families decision to make their children work rather than to educate them. Further, poor families are unable to invest in children's education. Investments in children's education are likely to be higher and career aspirations are likely to be encouraged in economically advantaged families. These enhance an adolescent's perceptions of the pathways to adult status open to her.

- **Poverty is the main underlying cause of malnutrition.**

Malnourished children have lifelong health problems and slower mental development. Malnutrition and associated health problems are more common among girls than among boys, because in many societies the status of women is low and girls and women are last in the line for food.

- **Malnutrition for girls in early life leads to anaemia, which intensifies after the start of menarche. Malnutrition and anaemia contribute to many of the problems found in pregnancy, childbirth and maternal death.**

## Low educational attainment and unemployment

- **Opportunities for education and employment greatly influence adolescent sexual behaviour and reproductive health.**

Where such opportunities are restricted, the opportunity costs of teenage parenthood is perceived to be low. One does not necessarily forego other options where options do not exist.

- **Education and career opportunities are negatively associated with unprotected sex and early pregnancy, and positively associated with contraceptive use.**

- **In many societies, educating daughters is given very low priority.**

Their roles are perceived to be wives and mothers, rather than individuals. Investing family resources in educating girls is not considered worthwhile because it would benefit the husband's family rather than the parents. Lack of education and training leaves girls with no option but to marry early and consequently face reproductive health problems.

## Gender bias and role stereotyping

- **Existing gender inequality results in lower awareness of and lower access to reproductive health services and information for girls than boys.**

- **Girls have lower access to food, health care and education. Malnutrition combined with early and repeated childbearing severely damages the health of millions of young women.**

Malnutrition is more common among girls than boys. Medical attention is sought more promptly for boys, but delayed for girls. Because of son preference in many parts of the world, a woman may have to undergo repeated and unspaced childbirth until she produces at least one son.

- **Women and girls in many countries are caught in the vicious circle of gender stereotyping. Parents, families and societies perceive the role of a woman primarily as a wife and a mother.**

Parents view the girl-child as transient and want to hand over their responsibility by getting her married as soon as possible. She is then expected to do her duty by producing a male heir for her husband's family as soon as possible.

- **Girl children and adolescent women, whether they are married or not, often contribute substantially to the family income. Yet, their nutrition, health and training get low priority in their families.**

They work in the field, marketing the product, processing food, working in factories and offices. Even when a young woman

is the principal breadwinner, she may not have control over her income and how it is spent. Her position remains subservient to that of the men in the family.

## Peer pressure

- **Adolescents are greatly influenced by their peer groups. They consider the dominant behaviour pattern of their peer group as the norm, and do not wish to act or behave in any way that would seem different.**

A teenage girl who already had a baby says, "With me it was because my girl friends told me it was nice to go with a boy and in any case they made fun of me when I was nearly the only one in my class who hadn't got a proper boyfriend".[53] Similarly in many societies, boys, when they reach puberty are pressured to have their first sex to prove their masculinity. When many teenagers are sexually active, that becomes the norm and what they are expected to do.

## Urbanization

- **The world, especially the developing countries are rapidly urbanizing. Whereas in 1950, 29% of the world's people lived in cities, by the year 2000, it is expected to be 47%.[54]**

An estimated 16 million people migrate each year from rural to urban areas of developing countries, excluding China, accounting for about half of recent urban growth.[55] Just over 25% urban in 1975, developing countries were nearly 40% urban by 1995.[56]

Many more young people are living away from their villages, communities, and extended families, which had in-built checks and balances.

- **In the urban areas, they often live in unstructured, unsettled and impoverished conditions, which are conducive to free sex, teen pregnancy, induced abortion in dangerous conditions, and also STD and HIV.**

Lack of information about reproductive health services, or lack of access to such services make them more vulnerable. On the other hand, urbanization can reduce fertility for a time, because it delays marriage, separates spouses, and postpones childbearing.

## Migration

- **About 2 to 4 million people migrate internationally each year. Another 18 million people have filed their own countries as refugees.**[37]

- **Migrants, refugees and displaced persons, including adolescents are a specially vulnerable group. Most of them leave behind the support of traditional values, extended families, friends and familiar ways of life.**

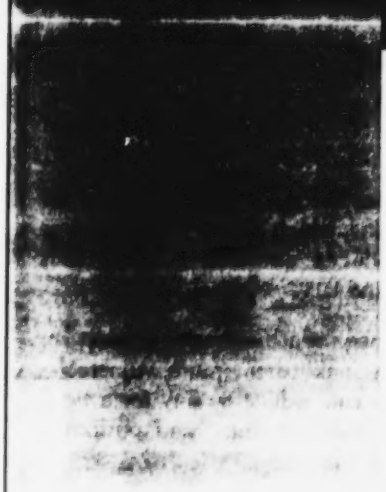
Culture and language barriers set them apart from their new neighbours. Reproductive attitudes and behaviour often differ as well. Many migrants are ineligible for health care benefits, unfamiliar with family planning programmes, and unable to obtain the necessary information.

- **Legal status of refugees is often unclear in the country of asylum. As a result, they may not get health care coverage for sometime.**

- **Among refugees and displaced persons, child-bearing can be life-threatening.**

Inadequate food and unsatisfactory shelter and sanitation make them susceptible to disease. Prenatal and delivery care is often minimal and emergency care non-existent.

- **Refugee women and adolescents are especially vulnerable to sexual abuse and rape. Some may have no choice but to trade sex for protection, money and food.**



## Mass media

- **The explosion of telecommunications across cultural boundaries is influencing the sexual behaviour of young people by providing so called "role models".**

The role models usually represent the dominant cultural practices of the economically developed western countries. In many countries in the west, it is socially accepted, indeed encouraged that teenagers experiment with adult patterns of language, dress and sexual behaviour. There are many adverse consequences of this behaviour pattern. However, in these same societies, there are often greater opportunities for education, training and employment; better reproductive health care and family planning facilities. In the developing world, where opportunities are limited, and health care and contraceptive availability inadequate, emulating western pattern of behaviour has disastrous consequences.

- **Adolescent behaviour patterns are greatly influenced by television. They tend to view reality as what they see on the screen.**

The values and lifestyles depicted on television, movies and through music videos exert powerful influence on the aspirations and desires of young people. Programmes which are sexually suggestive, strengthen the notion that being sexually active in one's teens is the normal thing to do. Unfortunately, adolescents may not be ready to judge effectively the accuracy or value of what they see or hear, and may simply follow styles and habits, both good and bad.

The influence of radio and television has penetrated deeply, even in isolated villages. Young people are exposed to the images of the urban middle class. These images fuel rural to urban migration of young people.

# SECTION FOUR: CONCLUSION

Adolescent reproductive health is a priority issue. This has been addressed in the ICPD Programme of Action which calls for removing barriers to information and services for reproductive health, especially for adolescents. However, several measures are needed to ensure progress in this area.

## 1. Policy Framework

Many countries have not formulated clear policies regarding reproductive health information and services to adolescents. Various socio-cultural and economic factors influence legislators and policy makers against addressing adolescent reproductive health.

Policy makers must be sensitized about these issues through advocacy, so that appropriate legislation is enacted and appropriate programmes are developed. These include legislation related to age at marriage, access to reproductive health information and services, and universal school education.

Advocacy is also required for programme managers, teachers, health care providers, community leaders and parents as their socio-cultural values influence the scope and the quality of reproductive health information and services available to adolescents.

## 2. Needs Assessment and Research

Country-specific and culture-specific information is required to support advocacy, and formulation of programmes. Issues relating to reproductive health are sensitive, specially where adolescents are concerned. The lives of very young adolescents are not typically documented. Their sexual attitudes and behaviours are not known when these years are supposed to be the most critical phase of their lives knowing that most of their expectation and beliefs are developed during this time. Since many of the adolescents are in school during this crucial period, these years are prime target for educational campaign. Curricula on adolescent reproductive health and sexuality should be based on the results of such research studies. Both quantitative and qualitative information is needed to understand attitude, values and behaviour of young people.

## 3. Planning, Designing and Implementing Programmes

Programmes should be flexible enough to respond to changing needs of adolescents and to address the heterogeneity among adolescents. Needs and requirements vary for younger and older adolescents, for the urban and the rural, for those in-school and those out-of-school, for the married and the unmarried, and for men and women.

Service providers must have the necessary technical and communications skills to deliver adolescent-friendly service. Educators and health workers need to collaborate in providing information, guidance and counselling.

## 4. Involvement of Adolescents in Planning, Implementation and Evaluation of Programmes

Active participation of adolescents in development, implementation and evaluation of programmes would go a long way to ensure that the programmes are relevant, well-targeted, gender

sensitive, flexible, and responsive to the needs of adolescents. Because of peer group influence, participation of adolescents in programme design and implementation is critical to communicating with them.

## 5. Formal and Non-formal Education Plays a Crucial Role in Educating the Youth on Reproductive and Sexual Health

Schools remain to be one of the most credible and important sources of information and education on reproductive and sexual health. However, many studies have shown that the youth turn to the mass media and their peers as the most popular sources of information. Very often however, such information are not only inaccurate but are sensationalized. This is where the formal instruction plays a role in providing accurate information tailored to the educational needs of the young, based on the cultural and religious environments of their communities.

In many parts of the world, the educational sector, both formal and non-formal, has introduced population education, family life education, sex education and the like in various forms and school levels. Very often however, these efforts are considered timid – they are introduced into the curricula in small amount, scattered and diffused in many subjects resulting in unconnected messages. They are also usually implemented in short period of time resulting in the preclusion of those disadvantaged adolescents who are likely to drop out of schools. Furthermore, they often only focus on the biological and technical aspects related to human anatomy and reproductive systems and changes during puberty and leave out the social and behavioural aspects dealing with dating, relationships, marriage and contraception aimed at developing life skills in decision-making, problems solving, values clarification and sexual negotiation which will prepare the youth in dealing with life's vicissitudes and problems concerning their reproductive health.

As is commonly misperceived, sexuality and reproductive health education does not encourage sexual activity among the young people. Studies indicate that sexuality education does not lead young people to engage in sex. In fact, most of these studies show that education on these subjects is associated with postponement of the first sexual experience and with the use of contraceptives among those who are sexually active.[58]

The second volume will deal more on the need for reproductive and sexual health in both the in-school and out-of-school sectors as well as the guidelines for developing an educational programme and curriculum in these fields.

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*Book Two:*
*Strategies and Materials on Adolescent Reproductive and Sexual Health Education*


**UNESCO PROAP Regional Clearing House on Population Education and Communication**

**United Nations Population Fund**

**Bangkok, 1998**




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# PREFACE

According to ICPD POA, the reproductive health needs of adolescents as a group have been largely ignored to date by existing reproductive health services. To meet the reproductive and sexual health needs of adolescents, information and education should be provided to them to help them attain a certain level of maturity required to make responsible decisions. In particular, information and education should be made available to adolescents to help them understand their sexuality and protect them from unwanted pregnancies, sexually transmitted diseases and subsequent risk of infertility. This should be combined with the education of young men to respect women's self-determination and to share responsibility with women in matters of sexuality and reproduction.

Motherhood at a very young age entails a risk of maternal death that is much greater than average, and the children of young mothers have higher levels of morbidity and mortality. Early child bearing continues to be an impediment to improvements in the educational, economic and social status of women in all parts of the world. Overall for young women, early marriage and early motherhood can severely curtail educational and employment opportunities and are likely to have a long-term, adverse impact on their and their children's quality of life.

In many societies, adolescents face pressures to engage in sexual activity. Young women, particularly low-income adolescents are especially vulnerable. Sexually active adolescents of both sexes are increasingly at high risk of contracting and transmitting sexually transmitted diseases, including HIV/AIDS; and they are typically poorly informed about how to protect themselves.

The crucial and critical factor that could contribute in alleviating or preventing adolescent reproductive health problems lie in education, information and communication. Adolescents should be given the opportunities to exercise their rights to reproductive health education, information and care or services. However, health care and information providers must safeguard their rights to privacy, confidentiality, and informed consent, respecting cultural values and religious beliefs. Any programmes on reproductive health should include support mechanisms for the education and counselling of adolescents in the areas of gender relations and equality, sexual abuse and violence against adolescents, responsible sexual behaviour, responsible family planning practices, family life, reproductive health, sexually transmitted diseases including HIV/AIDS.

Information and education programmes should not only be targetted at the youth but also at all those who are in a position to provide guidance and counselling to them, particularly, parents and families, service providers, schools, religious institutions, mass media and peer groups. These programmes should also involve the adolescents in their planning, implementation and evaluation.

Being a sensitive and often, controversial area, adolescent reproductive and sexual health issues and information are very often difficult to handle and disseminate. Furthermore, the contents do not only deal with factual and knowledge-based information but more importantly, need to deal with attitudinal and behavioural components of the educational process. This in turn, requires that the educators, information and service providers should be equipped with adequate knowledge and skills in handling sensitive topics, in promoting clarification of values and problem solving as well as ensuring involvement of

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adolescents in the analysis of their own values and beliefs with regard to such topics. To assist in developing such expertise in dealing with adolescent reproductive and health issues, this handbook is being developed for educators, information providers, counsellors, service providers, and peer educators. It will basically serve as a reference tool, which will provide guidelines, teaching/training strategies and actual sample lessons or activities to be used in counselling and educating adolescents in various aspects of reproductive and sexual health.

## Objectives

This handbook is a result of information repackaging programme of the Regional Clearing House on Population Education. Information and materials on adolescent reproductive health is rapidly growing. The Clearing House has initiated a collection and database on this subject and countries have started to contribute the materials that they have so far produced. These materials in turn need to be shared with the countries in synthesized, processed and consolidated forms. With the assistance of **Ms. Sunanda Krishnamurty**, consultant, **Mr. Sheldon Jacobs**, consultant and **Ms. Carmelita L. Villanueva**, Chief, Regional Clearing House on Population Education, this repackaging effort resulted in two volumes.

The first volume entitled, **Book One: Understanding the Adolescents and Their Reproductive and Sexual Health: Guide to Better Educational Strategies** focuses on the demographic profile of the adolescents, as well as their fertility, sexual behaviour, incidence of STDs, HIV/AIDS, teen pregnancy and abortion, and the like. It also analyses the factors and problems associated with adolescent reproductive and sexual health as well as the causes of the unhealthy development of adolescents. Recommendations are provided by the author to address the various issues and concerns on adolescent reproductive health, which includes education among others.

Volume two entitled, **Book Two: Strategies and Materials on Adolescent Reproductive and Sexual Health Education** provides the actual strategies, techniques and guidelines for integrating contents on adolescent reproductive and sexual health into the curriculum. It provides as a backgrounder a comprehensive analysis of the gaps and problems in introducing reproductive and sexuality issues into the curriculum, the response of the countries and the need for carrying out a more systematic programme on it. More importantly, it provides a definition of what a reproductive and sexual health education covers, the various strategies that can be used to introduce an educational programme on it and lastly, the elements that can be considered in formulating the curriculum on the subject.

The objectives of the two volumes are:

1) To develop better understanding of the issues and problems associated with adolescent reproductive and sexual health in order to deal with them in a comfortable and effective manner

2) To develop skills or ways and means of integrating messages on adolescent reproductive and sexual health into the curriculum

3) To provide ready reference of exemplary strategies and curriculum/ training materials as tools in teaching, training and counselling on adolescent reproductive and sexual health

4) To provide the educators with an over-all view of the literature that exist on the subject of adolescent reproductive and sexual health

## Sources

The two volumes were compiled using the available materials in the Regional Clearing House on Population Education collection, from the UNFPA documents and materials, as well as from the UNFPA Country Support Teams whose Advisers collect these materials arising from CST technical meetings held every year. A few others were obtained from other international organizations and countries in the region. Acknowledgment is due to the staff of the Clearing House for assisting the authors in literature searching, retrieving, photocopying and putting the bibliography in order.

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# PART ONE: PROBLEMS, RESPONSES AND GAPS

## A. Problems

❖ **For many years, the needs of adolescents have largely been neglected in population and reproductive health programmes.[1]**

There were many reasons for this. Issues relating to adolescent sexuality and reproductive health are extremely sensitive. Lack of training and awareness among health professionals and educators, and misconceptions surrounding the needs and impacts of adolescent reproductive and sexual health (ARSH) programmes have in the past prevented the implementation of effective ARSH education programmes in Asia.

Studies of parents, teachers and health personnel indicate that they are unprepared to discuss sexuality with adolescents, often because they feel uncomfortable or overworked, or because they disapprove of young people who express an interest in sexuality.[2]

In the past, the reproductive health education needs of adolescents were incorporated into programmes designed for adults or were ignored completely in educational and health programming. Moreover, much reproductive health programmes and services are focussed on married couples and adults, ignoring the needs of sexually active and sexually non-active adolescents.

❖ **Lack of information, misinformation and misunderstandings about conception, family planning and STD risks abound among adolescents.**

As a result, most teenagers get their information about sexuality and family planning from their peers, whose views are often inaccurate, based on rumors, and riddled by misconceptions; as well as from the mass media which very often present sensationalized and mixed messages resulting in anxieties and confusion among adolescents who fall prey to prevailing myths and misconceptions.[3]

Among Asia-Pacific youth, there is widespread ignorance of behaviours that expose young people to pregnancy and infection from STDS, including HIV/AIDS.[4] Without intervention, these myths and dangerous practices such as unsafe sex are likely to be carried over to their adulthood, creating problems for family and marital relationships.

In many countries, there are legal and service obstacles to providing adolescents with reproductive health services. For example, unmarried adolescents may be fully restricted from discussions of sexuality or provided only with instruction on female anatomy and abstinence.

## Misconceptions and Misinformation Abound

**Studies of adolescents highlight a number of misconceptions:**

**Among one-hundred young girls who came to hospital in India to seek an abortion, eighty per cent did not know sexual intercourse could lead to pregnancy or STDs; ninety per cent did not know about contraception.[5]**

**Many studies find adolescents don't believe it is possible to become pregnant during first intercourse. Some think oral contraceptives protected against STDs.[6]**

**In one study, adolescent fathers revealed a limited knowledge of even the most basic issues of reproduction. When asked why they thought their girlfriends would not get pregnant, replies included: "She didn't look like the type to get pregnant; We only had sex once a week; and, I didn't think she would get pregnant because she had such little breasts".[7]**

- **Despite the progress being made in improving the role and status of young women in the Asia-Pacific region, the attainment of gender equality, equity and the empowerment still requires more intensive work in many countries.**

The nature and extent of the differences accorded to boys, girls, men and women vary among Asian countries. When gender equality is restricted, girls and women have limited ability to make informed choices in matters related to reproductive and sexual health, and family formation. Differences in gender status and division of responsibility accorded to young men and women in sexual and reproductive health matters often result in risky practices and threats to health. Young single women in many Asia-Pacific countries are reluctant to raise the issue of contraception with boyfriends. Many women feel that discussion of contraception and STDs will lead their partner to suspect that they had previous sexual experiences leading to loss of the boys' respect and damage to the relationship.[8]

- **Unmarried, sexually active females represent an unreached target group that are at great risk of becoming pregnant, with almost all unwanted pregnancies among this group terminated by induced abortion.[9]**

The exceedingly high level of abortion in the region threatens the life of mothers and children particularly when the abortion is performed under unsafe conditions.

## B. Responses

### ICPD POA Response

The outcome of the International Conference on Population and Development (ICPD) held in Cairo, Egypt in 1994 represented a major change and increased emphasis on the need for adolescent sexual and reproductive health education.

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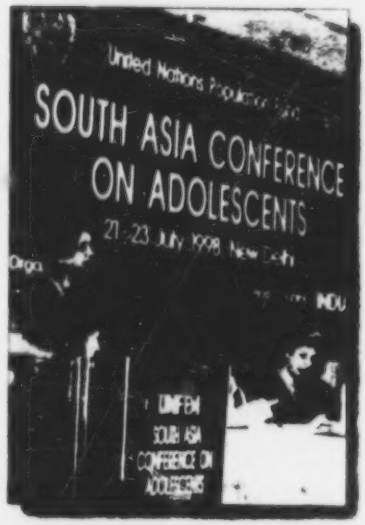
❖ **In the Programme of Action (POA) adopted at ICPD, the international community acknowledged for the first time that adolescent sexual and reproductive health involves a specific set of needs which are distinct from adult needs.[10]**

The ICPD POA further stated that governments with the support of the international community and non-governmental organizations should protect and promote the rights of adolescents to reproductive health education, information and care to meet the special needs of adolescents through appropriate programmes to respond to those needs.[11]




In providing education, counselling and services to adolescents, the ICPD POA states that countries must ensure that the programmes and attitudes of health-care providers do not restrict the access of adolescents to appropriate services and the information they need, including on sexually transmitted diseases and sexual abuse.

The needs and objectives for education and services laid down in the adolescent component of the ICPD POA includes:

**Components**

- **Promotion of responsible and healthy reproductive and sexual behaviour.**
- **Providing information and services to adolescents to help them understand their sexuality and protect them from unwanted pregnancies, sexually transmitted diseases and subsequent risk of infertility.**
- **Education of young men to respect woman's self-determination and to share responsibly with women in all matters of sexuality and reproduction.**
- **Reduce substantially all adolescent pregnancies.**

Programmes should include education and counselling of adolescents in the areas of gender relations and equality, violence against adolescents, responsible sexual behaviour, responsible family-planning practice, family life, reproductive health, sexually transmitted diseases, HIV infection and AIDS prevention, and the prevention of sexual abuse.

Moreover, initiatives must safeguard the rights of adolescents to privacy, confidentiality, respect and informed consent, respecting cultural values and religious beliefs.

❖ **The ICPD specifically highlighted the rights of adolescent women with regards to issues of gender inequality, their greater vulnerability to unprotected sexual activities, and stressed the rights of young women to reproductive health information and services.[12]**

Dr. Nafis Sadik, Secretary-General of the ICPD and Executive Director of the United Nations Population Fund, in her address to the South Asia Conference on Adolescents in 1998, illustrates the critical importance of providing comprehensive sexual and reproductive health education for girls and young women:

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"Education is important for everyone, but it has special significance for girls. It empowers them in multiple ways: they are likely to marry later and have smaller families since they can recognize the importance of health care and know to seek it for themselves and their children. Education helps girls to know their rights and gain the confidence to claim them" [1]

- **Responsible sexual behaviour, sensitivity and equity in gender relations, particularly when instilled in the formative years, enhance and promote respectful and harmonious partnerships between men and women.**

The ICPD POA states that human sexuality and gender relations are closely interrelated and together affect the ability of men and women to achieve and maintain sexual health and manage their reproductive lives. Equality between men and women in "matters of sexual relations and reproduction, including full respect for the physical integrity of the human body, require mutual respect and willingness to accept responsibility for the consequences of sexual behaviour".

**Countries' response**

- **In response to ICPD POA, there has been considerable efforts by countries in the Asia region to introduce adolescent reproductive and sexual health (ARSH) programmes. In the past, many countries in the Asia Pacific region have no ARSH policy, or ARSH was a small part of several different policies on population and reproductive health.**

A few of these countries have formulated a holistic ARSH policy that involve all agencies engaged in various activities aimed at reaching the young with ARSH messages. Many however, have sporadic activities which formed part of their other youth programmes. Starting in 1998 though, there has been an acceleration of efforts to address adolescent reproductive and sexual health problems on a more systematic and orchestrated manner. Most commonly, ARSH is treated as a sub-programme of the UNFPA-funded reproductive health programmes usually executed by ministries of health. In addition to this, the adolescents are categorized into various sub-groups and different agencies, both governmental and non-governmental, are assigned their specific roles and responsibilities for covering and reaching their respective youth sub-groups. Consequently, different agencies follow different modalities for reaching the teens from school-based to non-school based and health care/ counselling approach. The UNFPA-European Commission Initiatives also embarked on a large-scale programme to respond to adolescent reproductive health needs through the NGO mechanism in selected countries in the region.

### 1. In-school initiatives

School-based programmes started off with population education and family life education programmes introduced in various school levels from primary to secondary to tertiary. Funded by UNFPA, most of these programmes were demography-oriented focusing on the interrelationships between population growth and various aspects of quality of life. Gradually, contents on reproductive and sexual health were incorporated such as those dealing with risky behaviour, sexual violence, family planning, responsible parenthood, STD/HIV/AIDS, social aspects of sexuality education, gender equity, and boy-girl relationships. The gradual introduction of ARSH contents were deliberately done in order not to alienate the sector of society which has articulated their misgivings and could eventually jeopardize the full acceptance of such programmes. It has been observed though that those countries



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which continue to receive support from UNFPA were more likely to incorporate contents on reproductive and sexual health into their curriculum and teaching while those which do not, continue to teach the population growth and development paradigm.

### 2. Out of schools links to in-school initiatives

Because its traditional environments often inhibit the formal education sector from adopting innovative strategies in this area, outside interventions are usually relied upon to introduce changes in the schools. In this case, non-governmental organizations have been called upon to assist ministries of education to develop and implement reproductive and sexual health education programmes in many countries in the egion. Their involvement usually ranges from teacher training to student orientations and seminars, to youth camps and production of materials. A few examples include the following:

In Thailand, the Planned Parenthood Association of Thailand assisted the Ministry of Education to train teachers on sex education. A similar activity was carried out by the Planned Parenthood Federation of South Korea which included training for teachers and student leaders.

In Malaysia, the Federation of Family Planning Associations of Malaysia has provided talks on family life education in youth camps and schools, and provided training to teachers on reproductive and sexual health. In Indonesia, books and supplementary readings have been developed by an NGO for youth and trained youth groups selected by schools and teachers. One of the clinics organizes information provision on reproductive health for senior high schools.

### 3. Out-of-school initiatives

Out-of-school programmes range from use of peer approach where out-of-school youth provide information to each other in focus group discussions, to seminars and youth camps, to use of health care delivery services, counselling, telephone/hot line, training, mass media campaigns, use of entertainment and other cultural vehicles such as street plays, sports fests to income-generating activities where reproductive and sexual health messages are delivered to the youth. In some cases, innovative approaches have been developed to reach some of the hard-to-reach groups, such as the out-of-school youth.

The Family Planning Association of the Philippines has operated the Development and Family Education for Youth (DAFLEY) project since 1983, providing comprehensive health services designed to help youth understand the adverse consequences of teenage pregnancy and early marriage. Provision of services through a Teen Centre equipped with recreational facilities and a mini-library utilizes audio-visual facilities and indoor games A telephone hotline service run by well-trained youth volunteers and community activities such as sports are utilized as a way of effectively reaching youth.[14]

In India, a youth campaign on HIV and gender relations produced posters stating "Youth campaign to contain deadly HIV virus" with an illustration of four hands clutching each other, symbolizing solidarity, strength and mutual respect. Two hands wearing bangles expressed the equal participation of women, mutual respect and gender sensitivity issues involved in HIV/AIDS prevention education. A series of consultations were organized with youth leaders to formulate effective means of communication and programme development for AIDS prevention. Street plays, AIDS games and the creation of a network among youth NGOs to introduce peer educators were utilized.

In Cambodia, the European Commission and UNFPA cooperates with a number of NGOs to target out-of-school adolescents including commercial sex workers, rural adolescents, migrant youth and youth living on the streets through strategies such as interactive radio programmes, anonymous question-box facilities and peer education.[15]

## C. Gaps and obstacles

Despite some progress in developing ARSH education programmes, efforts have fallen short, with many gaps in content and the widespread use of ineffective strategies. Right from the start, a number of constraints have been pointed out which make reproductive and sexual health education difficult to introduce or carry out in schools.

- **Reluctance of policy makers, community members, parents and teachers to confront issues of sexual and reproductive health.**

A large number of administrators from the education sector are traditionalists – usually taking cautious decisions and policies that will not antagonize the parents, teachers and the greater community. The discomfort and bias among adults with regard to adolescent's sexual and reproductive health needs is an enormous challenge. According to Dr. Nafis Sadik, a key element in developing effective ARSH programmes lies in raising awareness among people who impact the lives of young people:

> "The largest challenge facing us does not lie in resources or delivery systems or even infrastructures, but in the minds of people. We must be sensitive to cultural mores and traditions, but we must not allow them to stand in the way of the actions we know are needed. We have to overcome the obstacles of superstitions, prejudices and stereotypes. These changes may not be easy and we face formidable challenges. They involve questioning entrenched beliefs and attitudes, especially toward girls. Lifelong habits must be given up, but they have to be, because in the end Asia's future depends on all its people: and it will depend as much on adolescents as on adults"

- **Existing population or family life education programmes often have little or no relationship to the real choices and pressures around sexual and reproductive health that affect the young people in question...the concentration upon the biology of human reproduction precludes it being viewed in the social and cultural context in which sexual behaviour takes place.**[16]

In this environment, uncomfortable topics tend to be dealt with in a rapid and cursory manner, with little follow up. This approach instills a false sense of security in adolescents, whereby they feel they are more informed and capable in reproductive health issues than they in reality are. More attention to the quality of education including increased review and reinforcement of concepts, skills and opportunities is required.

- **In many programmes, curriculum and textbooks continue to limit their focus on biological, demographic, population and development, and family life education issues.**

Reviews of adolescent reproductive and sexual health education programmes undertaken by UNESCO's Regional Office in Bangkok found the contents and methodologies

followed to be weak and inadequate, especially in developing skills among the teenagers in decision making, problem solving, clarifying their values and coping with changes during puberty. Programmes tend to concentrate on biological facts and human reproduction anatomy, with social issues given very little attention.[17]

In addition, mainstreaming new reproductive and sexual health issues into the already overcrowded curriculum often meets resistance and is strategically difficult. Further, these topics are not given due importance because they are not included in the test items of national examinations.

- **An important determinant of success or failure of a reproductive and sexual health education programme is the teacher. In spite of a well-designed curriculum, an ill-prepared or uncomfortable teacher can render a programme ineffective.**

Teachers, even if they are trained, often do not possess the inherent personality, values and skills required in teaching sensitive sexuality topics, resulting in more harm than good. Persons who express deep resentment towards teaching sexual and reproductive health and those who hold strong views about controversial (especially sex-related) issues and try to push them on others, are inappropriate candidates for the role of adolescent reproductive health educator.

An effective teacher is a pivotal element in a functional adolescent sexuality education programme. In addition to competent knowledge of the substantive issues of sexual and reproductive health, it is the quality of the personal interaction between students and teachers that can bring success or failure to a programme. Developing teachers for sex and reproductive health programmes entails strong support from administration, careful selection of candidates for the job, thoughtful consideration of sensitive issues and how to convey those issues, and time for instructors to practice teaching methods with colleagues.[18]

Gender bias among teachers must be monitored, as they will often reflect values developed from their culture and traditions. In South Korea, for example, a study revealed that a large number of teachers possess a strong bias against girls.[19]

- **Teaching methods used are often not suited to the sensitive nature of sexual and reproductive health education issues.**

In some countries, for example, while curriculum has been updated to include topics such as developing self-esteem, assessing needs and how to fulfill these needs, career path and goal setting, family communication, sexual behaviour (love, dating, sexual exploitation) and selecting a life partner, the methodologies used are still based on lecture, question and answer, and discussion method. The lack of a more participatory, activity-oriented approach does not provide opportunities for students to speak openly among their peers and teachers on sensitive personal issues of sexuality and reproductive health.

- **In the area of gender development, teaching modules do not clearly and sharply present the relationship between empowerment and improvements in women's reproductive health, fertility and sexual behaviour.**

Most of the lessons at elementary and secondary levels focus on broader women's issues taken up normally in social studies, home economics and civic responsibility such as improvement of women's status in home, profession and career, leadership, employment, etc.

These are of course desired but more lessons should also include how improved women's status could result in healthier adolescents, and healthier mothers and children.

Moreover, segregation of curriculum into separate units for 'women's issues' perpetuate ignorance regarding the reciprocal nature of sexual and reproductive health decision making and choice. Consequently, there are few opportunities for young men and women to gain an understanding of gender equity together and share in the practice of communication and negotiation skills.

- **Inconsistencies and inequities in the treatment of gender and sex roles can still be observed in many of the curriculum contents.**

While some lessons are very forward looking and genuinely and accurately promote improvement of women's status and gender equity, there still exists a number of lessons reflecting the traditional thinking and the personal values of curriculum developers and teachers.

Examples of gender biases include: responsibility for contraception and STD protection is located in females; stereotypical messages that women are responsible for their own sexual conduct and that of their partner; responsibility for unwanted pregnancy rests solely on the woman; activities dealing with home and family life are exclusively women-based; and, the perpetuation of sexist roles with regard to family activities and duties. Thus, opportunities for young men to develop a deeper understanding of their role in women's sexuality and reproductive health are generally deficient in the curriculum.

- **The exclusion of safe sex and contraception instruction in some curriculum may fail to develop skills in contraception and safe sex practices in future relations, both in adolescence and in adulthood.**

In the area of responsible sexual behaviour, safe sex is often absent from the curriculum placing adolescents who become sexually active at extreme risk.

In China, for example, the puberty education programme seeks to "cultivate sexual morality and avoid early love and sexual deviance", but does not include "safe sex and excludes knowledge of contraception". The 1997 policy document from China's Population and Puberty programme explains "the fact that early love and early pregnancies among the school students, being rare and occasional, are far from a social problem", and further that inclusion of safe sex issues "would not be tolerated by the society, the parents in particular."[20]

However, in the same document, policy-makers acknowledge the growing challenges and unchecked influences adolescents face in the area of sexuality and reproductive health: "abnormal activities exist in vast quantity in the cultural and recreational fields while China is undergoing reshaping of its economic system. Violence and sex fill quite a number of the literary works and screens, and are likely to mislead adolescents."[21]

- **Lessons observed in some countries have strong moralistic dimensions.**

In Malaysia, for example, religious schools have always played a major role in providing sex education with strong moral dimension and it was felt that they have accomplished their goals. It was suggested that it is now time for non-sectarian schools to teach sexuality education from its social dimension.

In some lessons a defensive posture is taken: "the availability of contraceptive and birth control gadgets also enable the young people free of responsibility over sexual behaviour.

Parents should instill high moral values among their children's attitudes and behaviour during the critical stage of development."[22]

Presenting reproductive and sexual health education solely in the form of prescriptive religious or morals instruction tends to inhibit communication and analytical activities such as values clarification, decision-making and problem-solving. Feelings of shame, fear and guilt may arise when adolescents perceive their behaviour is inconsistent with teacher or school expectations and become counterproductive to developing self-esteem and self-determination in deciding freely on issues of one's sexual and reproductive health.[23]

- **Family planning and ARSH programmes have traditionally delivered the same packages to all areas of the country. A major shortcoming of this approach is its failure to recognize that Asian countries are often diverse and pluralistic, containing sub-groups with different social, economic and cultural characteristics.**

The pattern of funding and the working strategy adopted under many ARSH education programmes has resulted in centralized planning and centralized decision-making. While national support and curriculum development is encouraged, strict, centralized programmes face difficulties in finding acceptance and building consensus among local community members, schools and teachers.

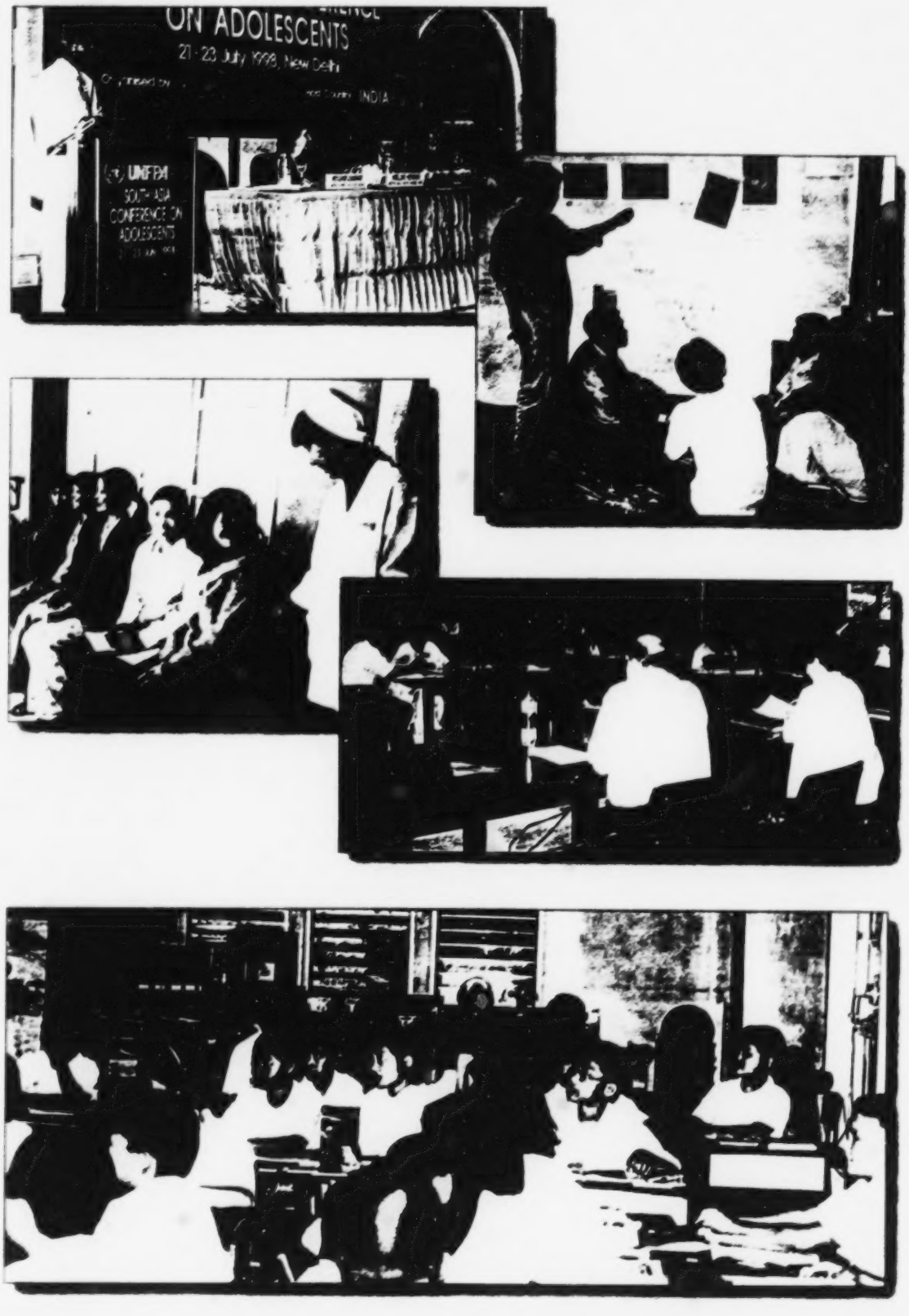
Inflexible curriculum and methodology guidelines may also fail to address the varying needs of different segments of the adolescent population. It is important, for example, to address differences between rural and urban populations, and adolescents with different cultural and socio-economic backgrounds and influences.

## D. Some successes and hopes

Despite the shortcomings and gaps, educators should not be discouraged in introducing adolescent reproductive and sexual health education in schools. It has been found out from research studies that sexuality education does not necessarily lead to promiscuity. In fact, recent studies point to the contrary. Below are findings which were culled out from a review of scientific articles on sex education programmes by WHO; a literature review commissioned by the UNAIDS to assess the effects of HIV/AIDS and sexual health education on young people's sexual behaviour; the Center for Disease Control and Prevention (CDC) of the United States and the Sexuality Information and Education Council (SIECUS). Although majority of the studies were done in the developed countries, situations in developing countries also formed a substantial part of these studies.

In summary, these reviews show that fears that sex education encourages or increases sexual activity among the adolescents appear to be unfounded as shown below:

- Education on sexual health does not necessarily encourage increased sexual activity. The researchers found "no support for the contention that sex education encourages sexual experimentation or increased sexual activity. If any effect is observed, almost without exception it is in the direction of postponed initiation of sexual intercourse and/or effective use of contraception."[24]
- Good quality programmes help delay first intercourse and protect sexually active youth from STDs, including HIV and from pregnancy by use of contraceptives.
- Studies have also shown that women who received formal instruction on contraceptive use before their first sexual intercourse were more likely to use a method. It was also found that among those who received formal education about AIDS and family planning, there was a decrease in number of sexual partners and an increase in consistent use of condoms.[25] Pregnancy rates were also lower, as a result of effective contraception and of reduced sexual activity.
- Teenagers who participate in sexual health education before becoming sexually active are more likely to delay initiation of sexual activity.
- Responsible and safe behaviour can be learned.
- More responsible and respectful relations between the sexes can result from education on gender and sexuality.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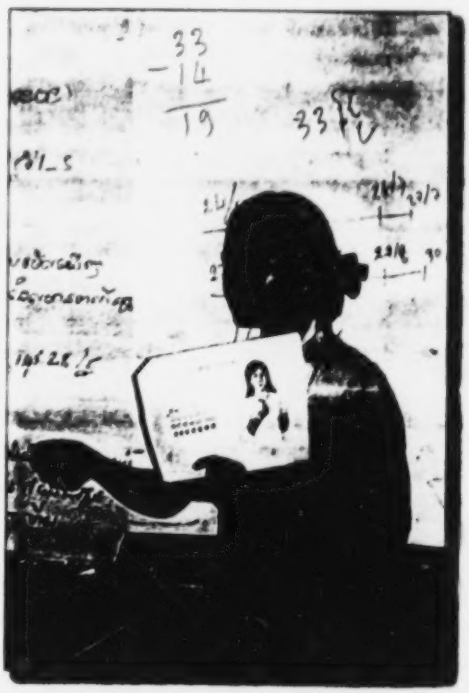
# PART TWO: REQUIREMENTS AND STRATEGIES IN INTRODUCING AN EFFECTIVE ADOLESCENT REPRODUCTIVE AND SEXUAL HEALTH EDUCATION

## *What is reproductive and sexual health education?*

**Reproductive and sexual health education is an educational experience aimed at developing capacity of adolescents to understand their sexuality in the context of biological, psychological, socio cultural and reproductive dimensions and to acquire skills in making responsible decisions and actions with regard to sexual and reproductive health behaviour.**

The most comprehensive reproductive health and sexual health education programmes not only cover the biology and anatomy of reproduction and sex, but also provide young people with information about dating, boy-girl relationships, marriage and contraception. They help develop the skills necessary to resist peer pressures, inappropriate sexual advances and to attain a level of maturity required to make responsible decisions. They carry lessons on goal setting and career planning.



Attitudes, behaviour and skills to protect them from unwanted pregnancies, STDS, risky sex, sexual abuse, unsafe abortions, as well as development of respect for the human body, sensitivity and equity in gender relations, including respect of women's self determination in matters of sexuality and reproduction are key elements of ARSH education.

Young people are rarely provided with adequate knowledge about their own development, especially in regard to sexuality, the changing human relationships which take place during adolescence, and the benefit to boys and girls of equity between the sexes. They need to develop their capacity to communicate and make plans and decisions during a time of life in which their own autonomy is increasing.

They need knowledge about appropriate exercise, rest and nutrition and the special needs of young women. They need to know how to protect themselves against illness and injury, including the consequences of drugs, sexual abuse and exploitation, and how to prevent pregnancy, STD and HIV infection.

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In much of the world, young people lack specific information about how to make use of existing services. They often do not know what is available, where it is, how to use it, what will happen when they get there, what it will cost, whether it will be confidential, private or painful, what will follow and, perhaps most important, whether they will be welcome.[26]

Programmes for adolescents can have a wide variety of objectives, some of which relate directly to outcomes for the adolescents and others that relate indirectly to adolescents by focusing on improvements in programme functioning or the policy environment that ultimately would affect adolescents. Examples of direct objectives include:[27]

## What is new in reproductive and sexual health education?

**Objectives**

- **Better understanding of physiological and emotional changes during puberty,**
- **Increasing knowledge about reproductive health,**
- **Increasing access to reproductive health information/ counseling,**
- **Increasing access to clinical reproductive health services,**
- **Improving communication among family members,**
- **Enhancing sexual decision-making/negotiation skills,**
- **Building self-esteem,**
- **Delaying initiation of sexual activity,**
- **Increasing safe sex practices,**
- **Delaying first pregnancy, and**
- **Increasing spacing between first and second births.**

In the past, population education and sexuality education programmes focussed primarily on the biology of reproduction. Male and female physiology and reproductive processes were explained with little reference to the social-emotional issues and the cultural context of adolescent's reproductive and sexual health. Fertility reduction and family planning were stressed.

Teaching approaches focussed on traditional lecture style stressing memorization of anatomical structures. Much education was fear-based and authoritarian, focussing exclusively on the pregnancy and disease aspects of sexual activity. Moreover, the approach of censuring certain topics as unacceptable in the context of adolescent reproductive and sexual health education has left a number of gaps where adolescents have no outlet to explore the growing complexities of their reproductive, sexual, social and emotional development.

Contemporary reproductive and sexual health education aims to redress these inadequacies, by exploring a broad range of reproductive and sexual health issues that are the reality of today's adolescent. The rising incidence of teenage sexual activity, and its associated risks of pregnancy and disease require much more than simplistic lectures on anatomy and physiology. Attitudes and behaviours must be understood in the context of social structures and influences such as peer pressure, media influence and changes brought on by increasing urbanization and changing family values to name a few.

Previous programmes also focussed on knowledge gain, which widespread study has shown does not necessarily lead to behaviour change. Programmes implemented in the current climate stress the development of skills through participatory approaches. These include, for example, role playing in safe sex and responsible relationships, exploring a



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community clinic and developing strategies for resisting peer pressure. Messages and activities now include issues of gender relations and inequality, and are now inclusive of all adolescent target groups, e.g., the sexually active and non-active, homosexual students, out-of-school youth and others who may be considered outside the mainstream.

Below are selected strategies which ensure that adolescent reproductive and sexual health education programmes accomplish its objectives and goals.

## 1. Awareness building and advocacy to gain support from the community

In order to effectively carry out and sustain successful adolescent reproductive and sexual health education programmes, it is important to build awareness and alliances with others living and working in the same community. Awareness is critical to ensure adults in the community support the idea of developing and implementing a comprehensive programme that will address the real needs of the entire spectrum of adolescents in the target group.

Adult support for adolescent reproductive and sexual health programming requires early and continuous involvement of adult stakeholders, such as local elders, officials, and opinion leaders, in programme planning and implementation. Many adults may not be aware of the actual status of adolescent's reproductive health knowledge, attitudes and behaviour. Undertaking detailed assessment of the status and needs of adolescents is one method of illuminating the needs and actual behaviour of young people. If key adults are engaged in assessing the needs and behaviours of young people in their area, are consulted about intervention ideas, and are kept informed about programme performance, opposition is less likely to arise, and local ownership and support will be strengthened.

In India, for example, a survey of adolescents helped convince parents and community members of the need for a sex education programme; the survey revealed that many adolescents were sexually active, contrary to adults' beliefs that they were not.[28]

### *A. Involving Teachers*

It is important that programmes are prepared with the input and cooperation of both teachers who will be expected to implement the programme and teachers from other disciplines who may provide general support for the programme.

Teachers will often have their own concerns and degree of apprehension regarding such programmes and through empowering teachers in the development stage, they are more likely to view the programme as relevant. Teachers dealing with adolescents on a daily basis are in a strong position to provide valuable insights into the needs and strategies relevant to programme development.

### *B. Involving Parents' and Families*

It is important that parents feel comfortable about the programme their teenagers participate in. There are many forms for involving parents in ARSH education programmes. These include:[29]

- Involve parents as members of an ongoing advisory committee that reviews programme content and provides input into curriculum resources.
- Hold a meeting for parents that provides information about the programme and gives parents opportunities to review the programme content.
- Assign homework for children to complete with their parents. Through joint homework activities, parents gain opportunities to influence their children's development and may lead to increased family communication about reproductive and sexual health issues.
- Depending on the amount of parental involvement and support for the school's programme, there may be opportunities to offer programmes directly to parents to help them become more effective communicators and sex educators. Sessions for parents should target parents of both and preadolescents and adolescents, and may include some joint sessions where parents attend with their sons and daughters.

**Parent Education in Indonesia**

**In Indonesia, the Ministry of Population and Family Welfare (BKKBN) has launched a parent education programme in two Javanese provinces. BKKBN has produced separate parent-education curricula for younger and older adolescents covering reproductive physiology, family relationships, contraception, and other topics. This programme works through parents' groups that hold a series of meetings to discuss the content of the curricula and review parents' experience in discussing these issues with their children. Other adults, including religious and youth-group leaders, are also using the curricula to discuss these issues with young people.[30]**

### *C. Encouraging Community Collaboration and Involvement*

Involving a broad base of different adults and groups will strengthen any programme. Governmental and non-governmental organizations, neighborhood organizations, health providers, and youth agencies, the media, business sector, religious organizations and local leaders also play an important role. Their support can be especially important should opposition arise to progressive adolescent reproductive and sexual health programmes or policies. Different community groups can offer valuable skills, resources and perspectives, to strengthen a programme's ability to serve youth or refer them to other appropriate agencies.

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## 2. Use of socio-cultural research findings to ensure relevance

❖ **Research is the foundation of an effective sexual and reproductive health programme. Incorporating socio-cultural research in curriculum development ensures relevance and acceptability of the curriculum**

A sensitive programme of adolescent reproductive and sexuality health education must take into account the socio-cultural influences upon an adolescent's development. Adolescent reproductive and sexual behaviour occur in a social and cultural context. Thus, the development of objectives and strategies must incorporate socio-cultural research findings to ensure that programme goals and strategies are effective in identifying and addressing the needs of adolescents.

Below are some determinants of reproductive behaviour based on socio-cultural research findings explained in a paper by Marcela Villareal entitled, ***Adolescent Fertility: Socio-cultural Issues and Pogramme Implications*** (FAO, 1998). Their implications to curriculum development are highlighted as well.

### Gender Issues

**Findings:**

In South Korea, China, India and elsewhere there is strong preference for boy children. In South Korea, nearly 80,000 female fetuses were aborted between 1986 and 1990, about five per cent of all female births. In China, unwanted children put up for adoption are three times more likely to be girls.[31]

Many societies value very highly women's virginity and at the same time construct masculinity around sexual activity contradicting the aim to achieve gender equity and equality in boy-girl relationships. In Thailand, young people of both sexes look down on boys who do not have multiple sex partners, while studies in many countries show girls are suspected of being promiscuous if they suggest using a condom.

Often adolescent boys are likely to be motivated by peer pressure to have sex, while girls are overcome by their fear of losing their boyfriends. A gender issue related to pregnancy outcomes among adolescents is the perception by many males that contraception is a woman's responsibility.

**Implications for teaching and curriculum development**

Based on the above findings, the following contents could be considered in curriculum development:

**Contents**

- **Countering peer pressure to initiate sexual behaviour or "how to say no".**
- **Confronting society's 'double standard' that promotes virginity in women, while at the same time defining masculinity in terms of sexual conquest.**
- **Recognizing the various consequences of early pregnancy.**
- **Exploring the concept and cultural connotations and impact of concepts such as virginity, romance, beauty, family and marriage.**
- **Male involvement and responsibility in contraception and protection from STDs.**
- **Assertiveness for young women and men to confidently raise the issue and practice of safe sex.**
- **The historical and cultural roots of sex preference and its impact on family and male-female relationships.**

## Contraception, Pregnancy and Abortion

**Findings:**

The meaning assigned to pregnancy varies among different cultures. In most contexts, acceptability of teenage pregnancy is associated with marriage. In some countries, a pregnancy constitutes a prerequisite to marriage. In other countries, early marriage is in fact favoured to prevent the undesired effects of premarital sexual activity and pregnancy.

**Contents**

- **Concepts of marriage.**
- **Health risks and limited life planning options of early marriage and early pregnancy.**
- **Cultural and social messages surrounding relevant concepts such as sex, pregnancy, family and marriage.**
- **Showing how many adolescents feel trapped by the responsibilities entailed by early pregnancy and childbirth, unable to pursue their education and career and economic prospects.**
- **Handling sexual behaviour through appropriate sexual decision-making and consistent contraceptive use.**
- **Exploring decision-making issues surrounding abortion, including age of mother, impacts for future life plans, medical factors and genetic determinants.**

Given the social restrictions on adolescent sexuality and the cultural unacceptability of premarital pregnancy, abortion is a likely outcome, and is in part responsible for increased maternal mortality of adolescents.

Some women in Asia face severely restricted access to abortion because of cost, transportation problems or lack of parental consent, often resulting in greater health risk.[32]

**Implications for teaching and curriculum development**

Lessons following from the socio-cultural research on contraception, pregnancy and abortion may include lessons on:

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## Sexual Attitudes and Behaviour

**Findings:**

Various factors influencing early sexual activity in both males and females have been analyzed. These include: 1) lower socioeconomic status, 2) having a mother who had completed fewer years of education and, in particular, did not graduate from high school, 3) attending school education. Additional factors include 1) having a mother who is a teen parent, 2) living with a single parent, 3) being less religious, 4) having poor parental communication and discipline, 5) being less goal oriented, 6) use of drugs or alcohol, and 7) being influenced by peer pressure.[33]

Increase in premarital sexuality is attributed to various causes. For some countries, the process of urbanization and increasing influences of western culture are seen to be responsible for the breakdown in traditional customs. In other countries like in Asia, economic factors are seen as largely responsible for the rise in premarital sex.

In the process of urbanization, the changes in the traditional systems of social control contribute to an increase in premarital sex. As women change their location away from home, she escapes from the controlling eye of the father, the local priest and the community and with the weight of western values attractive to the young, often leads to destruction of local taboos.

Many surveys suggest that while young people declare they believe in God, yet few nowadays say that religious beliefs are the most important factors in their lives. Nonetheless, young people who attend organized religious activities frequently have less permissive attitude about sexual activities outside legal marriage.

**Implications for teaching and curriculum development**

Lessons following from the socio-cultural research on sexual attitudes and behaviour may include lessons on:

**Contents**

- **Trends in urbanization, changes in the traditional systems of social control and their relationship to increases in premarital sex and other sexual behaviour.**
- **Various factors influencing early sexual activity in both males and females.**
- **Role of education and impact of educational level on sexual behaviour.**
- **Changing attitudes toward religion and role of religion and religious institutions in the sexual decision-making process of adolescents.**

## Sexual and Reproductive Health Risk

**Findings:**

Studies strongly suggest that the motivation to prevent pregnancy is closely linked to an individual's perception of other possible life alternatives. High correlation between various at risk behaviours such as early sexual activity, truancy, alcohol and drug abuse is correlated with low self-esteem and a perceived lack of ability to make choices or affect their future. Conversely above-average levels of self-esteem are associated positively with better adjustment, more independence, less defensive and deviant behaviour, and greater social effectiveness and acceptance of others.[34]

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Studies conducted in Thailand, Zimbabwe, Malawi and Brazil have demonstrated that young people believe that AIDS is a disease of "outsiders," "bad people," "sinners," bar girls, prostitutes and homosexuals and that they are not at risk for HIV/AIDS.[35] Adolescents are prone to risk taking behaviour, motivated, in part, by the misperceptions that they are invulnerable.

Clinics are not always helpful to adolescents. Studies indicate that when adolescents approach clinics for help, they are often scolded, refused information, or turned away. In Thailand, young people refuse to go to clinics for fear of being seen by an adult family member or neighbours. Other young people report that they won't go to clinics because they do not think that clinics will serve them, or because they have been sexually abused and fear that clinic personnel will report them. Many are simply too young and inexperienced to know how to find a clinic. As a result of these barriers, adolescents usually first contact a sexual and reproductive health programme when they must deal with a pregnancy or a sexually transmitted disease. Also, sexual abuse and domestic violence is on the upswing.

**Contents**

- **Increasing self-esteem, ability to make choices and competencies required for setting future life goals.**
- **Availability of health clinics and services in the adolescent's community, how to access them and obstacles to health services for adolescents.**
- **Prevalence and impact of STD and AIDs in the world and the target group's locale.**
- **Illustrating the vulnerability of all adolescents to STDs, and other reproductive health risks, regardless of social, economic, gender or cultural status.**
- **Causes, prevention and options for victims of sexual abuse and domestic violence.**

**Implications for teaching and curriculum development**

Lessons following from the socio-cultural research on sexual and reproductive health risk may include lessons on:

## 3. Linking in-school and out-of-school programmes and activities

❖ **Few school programmes are equipped to meet all the needs of young people given the diversity of adolescent target groups and limitations in resources.**

This entails the expansion of schools programmes to contexts adolescents find meaningful and comfortable, such as call-in media shows and hotlines. Other programmes have successfully used discussion groups, youth camps, reproductive health clubs, peer-education groups in factories and schools, drama competitions and malling. These approaches can be used to make information meaningful and attractive.

To develop such strategies, programme planners need to analyze the youth's current needs and health-seeking behaviours. A first step is working with young people to determine where and how they spend time, obtain health information, and seek health services. Then programmes could be designed to use approaches favoured by those they are intended to reach.

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❖ **Working together through formal and informal referral networks saves resources, strengthen both partners, and prevent needless duplication of services.**

Schools can work with complementary organizations that exist within the community to provide youth with the needed spectrum of services. A school may partner with a local community clinic to provide contraceptive services on the school grounds, to provide visiting speakers or to improve referrals to the community-based site. Other examples of potential partners are NGOs, national youth-service programmes, Scouts, Girls Guides, YM/YWCAs, the Red Cross, and sports programmes and leagues.

❖ **Information must be linked to health services.**

The sexually active adolescent who has made a commitment to healthy sexual behaviour will have great difficulty doing so if she or he is unable to access reproductive health services, particularly contraceptives. Linking sexuality education to services is critical in ensuring that sexually active youth can protect themselves from pregnancy and disease.

Linked approaches, which share resources and referrals, might include a network of providers and settings that refer clients among them or a combined approach, where a clinic or school establishes outreach efforts. Linkages with non-governmental youth-serving organizations are also recommended to provide the widest base to the services extended to adolescents.

Comprehensive reproductive and sexual health services for adolescents may be offered in hospitals, schools, or community-based health facilities. Gynecological and other physical exams, contraceptive services, pregnancy testing, testing for STDs, including HIV, and treatment and/or referral for these diseases should be included in these services for youth.

The most effective services are teen-friendly, guarantee confidentiality, and offer accessible hours (including walk-in appointments) at convenient locations. A well-trained and non-judgmental staff person can be important in helping teens learn about and practice safe sexual behaviours effectively and consistently. Young people benefit most by receiving information or services from providers who are sensitive to their unique issues and styles of communication.[36]

❖ **The media have been found out to be a main source of ARSH information outside of schools. In many Asian societies studies reveal that television is the third major influence on the adolescents' lives after parents and peers.**

A discussion of sexual behaviour would be incomplete without addressing the impact of the media. Studies show that in the absence of a reliable source of information on reproduction and sexuality, young people turn to peers and the media. All forms of media are growing in Asia. More and more in Asia, television is becoming the major past time of young people. Incomes are rising in Asia while technology such as cable television, introduction of youth programming such as MTV and other forms of popular media reach an increasing number of youth.

Asian television is beginning to reflect the content found in the West where such programmes do not necessarily portray the prevailing norm for sexual activity. During American prime-time television, roughly three sexual acts per hour are presented, including deep kissing and petting. Only one of every six acts of intercourse is between married couples. In daytime serials, favoured among junior and senior high school students, there are more than

three and one-half sexual acts per hour, and non-marital intercourse is portrayed twice as often as marital intercourse.[37] On the other hand, it is rare for a character to develop a STD or become pregnant.

### Television, Sex and Behaviour

**Some studies have suggested that there is a link between the early onset of sexual activity and the sexual content of TV programming. People who watch a lot of TV tend to view reality as what they see on the screen. For example, watching sexually suggestive programming may help strengthen the notion that "everyone is doing it." Studies of college students who were shown sexually explicit films reveal that heavy doses of sexually suggestive programming may result in increased acceptance of infidelity and promiscuity and less disapproval of rape. Movies are even more visually explicit; music videos such as those on MTV frequently depict violence and sexual imagery. The media could be used to educate youth about positive sexual experiences and the risks of unprotected sex. Instead, the media send out mixed messages, making sex appear enticing while warning, "Just say no".[38]**

Reproductive and sexual health education programming must review the messages presented in various forms of media for bias and degree of reality. Questions should be asked as to why these messages mystify.

Re-working media in a way that is positive and empowering for adolescents should be looked into. Definition and notions associated with beauty, love, sex, marriage and family can be readily explored for their impact on the ideas, expectations and feelings.

## 4. Grounding programmes in social learning theory and social constructions

### Social learning and development theories

An article by Jane Hughes and Ann MacCauley, entitled ***Improving Fit: Adolescents' Needs and Future Programmes for Sexual Reproductive Health in Developing Countries*** which appeared in **Studies in Family Planning,** June 1998, identifies two types of theories that could be applied in developing adolescent programmes. The first include social learning theory and health-risk theory, which seek to predict risky behaviour to predict behavioural change. This makes use of interventions that will help the teenagers to understand better his/her susceptibility to a health problem and to help acquire motivation and skills to reduce risks.

The other theory called development theory on the other hand, covers a complex process of physical, cognitive, social, emotional and moral maturation (**WHO, 1993**). In order to meet basic personal needs, young people must develop a fundamental set of skills and competencies (**Kirby, 1997**). A young person's readiness to acquire one or more of the skills varies according to his/her stage of development (**WHO/UNFPA/UNICEF Study Group, 1998**). For example, adolescents find it difficult to plan ahead. The theory also states that a young person is shaped by his/her environment of home, family, community, the media, prevailing policy and cultural norms. Both health-risk behaviour and adolescent development theory share an implicit view that information and services alone are not sufficient to influence a young person to adopt safe health behaviours, and both stress that the young person learns



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skills on how to reduce risks but should also acquire generic skills such as life skills (planning ahead, seeking help, forming positive relationships, etc.).

### Social construction and social scripting

An effective programme must help students to understand the social and cultural influences on sexuality and reproductive attitudes and behaviours. Operating from a human development model that includes a *social construction* orientation, sexuality is viewed as a lifelong developmental process; human sexual behaviour is changeable and an individual's development is unique. By encouraging students to critically examine relationships between the personal and social worlds, particularly the impact of culture, history and ideology they are encouraged to identify the positive and negative impacts of the social world on their lives. Understanding social construction is a first step to formulating personal values, which is a critical step in determining behaviour.

Another term related to social construction is *social scripting*, referring to the roles society defines and enforces on for boys and girls. This refers to the process by which sexual thoughts, behaviours, and conditions (for instance, virginity) are interpreted and ascribed cultural meaning. This element incorporates collective and individual beliefs about the nature of the body, about what is considered erotic or offensive, and about what and with whom it is appropriate or inappropriate for men and women (according to their age and other characteristics) to do or talk about sexually. In some cultures, ideologies of sexuality stress female resistance, male aggression, and mutual antagonism in the sex act; in others, they stress reciprocity and mutual pleasure.

## 5. Highlighting gender equity issues and more male participation

### Providing a coeducational approach format

- **Many times information on menstruation is shared only with girls, while that of masturbation is shared only with boys.**

Young men and women live their lives and develop in a shared context. In the past, the sexes were often separated during reproductive and sexual health education classes. For example, male physical education teachers instructed sex education classes in boys' physical education classes, while female teachers did the same in the girls' physical education class.

Sexual scripting, which refers to the roles defined and enforced for boys and girls, often implies that human sexuality is specialized by gender; that is, boys need not be knowledgeable or too concerned about girls' sexuality, and vice versa. Although boys and girls exist in close physical proximity, in many societies they live in culturally separate worlds.[39] Open and realistic discussions with both boys and girls give children practice for a lifetime of healthy female/male communication both in personal relationships and in the workplace.

## Understanding the Opposite Sex

**Presenting boys with practical information on the cause of monthly menstrual pain, together with the realization that it may be used in certain circumstances as in attention-seeking behaviour, not only provides important facts, but also helps them understand that secondary status often forces girls to explore undesirable avenues of seeking attention. They, as boys, can help to make a difference. It is necessary to furnish complete information to both boys and girls so that mutual respect and understanding develops between them. Also, providing guidance can often channel sexual energy in a positive direction. Scientific knowledge and a logical thinking will prevent adolescents from distorting and perverting facts.[40]**

A coeducational approach does not exclude gender-specific elements of programming. Experienced educators have found that inclusion of separate sessions is important. For example, preadolescent girls are often anxious and embarrassed about menstruation and generally feel more comfortable discussing the details of menstrual hygiene without their male classmates present. Boys, also, may welcome the opportunity to air some of their personal concerns in an all-male session.

### Incorporating the needs of boys and young men

In a report published by the Swedish Association for Sex Education, the author Erik Centerwall outlines a number of pressures with implications for sexual and reproductive development. The following section draws heavily from findings in the report.[41]

#### *Pressure on young boys*

The world of young boys is often silent on issues of reproductive health and sexuality. In the area of sexual and reproduction there is often an embarrassed silence or a moralizing attitude. Either the role of male sexuality in the lives of women has been something of which not to speak, or the negative attitude, "that's what boys are like; they're only after one thing" is promoted.

In much of society, male sexuality has been rendered performance-oriented, which contributes to boys' perceptions that excessive demands are being imposed on them. For this reason they have also maintained silence concerning their own personal experiences. Sexual life and experiences have been turned into secrets and filled with embarrassments.

These approaches do not offer boys the opportunity to perceive the magnitude of their role in a relationship or their significance in relation to reproduction, health nor develop a positive self-image. Emphasizing joint responsibility for the consequences of love and stressing that the man should also participate in everyday life together with his children represent fundamental themes in information work focussing on men and adolescent boys.

Sexuality and reproductive health programmes must both educate and enable men to share more equally in family planning and in domestic and child-rearing responsibilities and to accept a major responsibility for the prevention of sexually transmitted diseases. Voluntary and appropriate male methods for contraception, as well as for the prevention of sexually transmitted diseases, including AIDS, should be promoted and made accessible with adequate information and counseling.

Boys and young men want to know that they are normal in physical, social, psychological and other aspects. It is often important for a boy to be part of the group.



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However, it is also important a boy knows he is special as individual as well, so that he can resist group pressure and dare to hold his own.

Opportunities to explore these issues are especially important as many young boys and men have no active father or other male role model to discuss and learn from. Absent fathers is common in Asia as it is in all countries of the world. Urbanization, economic pressures and changing attitudes towards the family are leaving more boys in Asia without an ongoing adult male in their lives.

### Absent Men in Asia

**In many Asian countries, many children do not have the close contact with their father that they wish for or need. Lack of male role models is a major problem for both boys and girls. It is especially boys who tend not to obtain the male guidance and closeness that generates the self-esteem needed for the creation of a masculinity, which permits interaction with women in a respectful and comradely manner. To interact with women, both on an everyday basis and in a more intimate context, requires both male self-esteem and a capacity to identify with the woman.**

Below is a more detailed listing of key areas that can be included in the school curriculum that address boys' sexuality and reproductive health:

### Key Areas

- **Male fertility**
- **Contraception**
- Sexually transmissible diseases
- **Pregnancy and becoming a father**
- Inter-play of masculinity and femininity
- **Male physiology**
- Ways of loving
- **Taboos concerning love**
- Male anatomy
- **The female world**
- Masturbation
- **Pornography**
- **Sexual exploitation of women**

### Addressing needs of homosexuals

One area of adolescent sexuality that is usually inadequately explored in education is that of gay and lesbian youth. This group is frequently unrecognized and is at risk for various adverse emotional and physical problems. One in 10 adolescents struggles with sexual orientation issues. Morover, a significant number of adolescents engage in homosexual behaviours while determining their identity.

'Identity confusion' is a normal part of adolescent development. Problems arise when adolescents face sexual identity confusion without adequate knowledge or support for homosexual ideas. Adolescents may avoid stereotypical homosexual behaviour and may resort to substance abuse as a way of dealing with the issues.

Nowadays, there is an increasing awareness and acceptance of gay men and lesbian women. However, much of the health and sexuality information available for young people and adults still assumes heterosexuality. This means that sexuality and health programmes may offer nothing to the up to 10 per cent of students who are gay, lesbian or bisexual.[42]

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### Homosexuality: Not a Psychiatric Disorder

**In the developed world, most have accepted homosexuality. In 1973, the American Psychiatric Association removed it from the Diagnostic and Statistical Manual of Mental Disorders. In 1983, the American Academy of Pediatrics recognized gay youth and stated that care providers of adolescents should be addressing this topic. Homosexuals are now largely accepted in most sectors of society such as politics, religion, business and the media.**

Pleasing the peer group, fitting in socially, and experimenting sexually are part of normal adolescent development. Teens who experience homosexual feelings contend with peer ridicule and face rejection in many aspects of their lives. The homophobic nature of society can lead to poor self-image and to self-destructive behaviour. Adolescents are then forced to hide their feelings without having a way to explore and resolve conflicts. Studies have shown that lesbian and particularly gay youth are at risk for various medical problems, including STDs and HIV.[43]

### Making the Invisible... Visible!

**Homosexual youth are often an invisible part of the adolescent community. The Indonesian Planned Parenthood Association's Lentara project developed a street outreach programme which reaches young homosexual men in the places they congregate and supports them to reduce their risk of HIV infection. The project also provides a venue for them to discuss issues such as sexual identity, relationships and sexual health.**

## 6. Use life skills approaches and strategies to ensure responsible behaviour development

In a review of the fit between adolescent needs and programming for ASRH in developing countries, Hughes, Jane and McCauley (1998) note the need to go beyond mere knowledge in developing effective programmes.

Although evaluations indicate that programmes can increase adolescents' knowledge, knowledge alone is not sufficient to ensure the adoption of healthy behaviours. Both theory and expert consensus argue that training in skills is a fundamental component of an effective adolescent sexuality and reproductive health programme. Life skills enable young people to translate knowledge, attitudes and values into actual abilities.

The World Health Organization defines a core set of life skills as follows:

Young people need to learn generic skills such as planning ahead, making decisions, and forming positive relationships as well as practical skills needed to avoid high-risk behaviours, for example, communication skills used to discuss safe sex with a partner and learning to use contraceptives. Life skills are so basic to life that they are often taken for granted. Yet with the changes to society and culture, many young people lack the necessary skills to deal with the increased demands and stresses they are faced with.


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Programme approaches should help students learn to set goals and to communicate with family and friends, including negotiation and dealing with pressure situations. In teaching life skills, students are dynamically involved in the learning process. Methods are needs driven based on the needs of creating a complete and authentic experience readily transferable to real-life situations. Working in small groups and pairs, brainstorming, role-playing, games and debates may all be incorporated. Role-playing difficult situations, community visits to learn about accessing services, and other means are used to teach skills such as how to protect yourself from a sexually transmitted disease.

### Core Set of Life Skills

- Decision making
- Problem solving
- Creative thinking
- Critical thinking
- Effective communication
- Interpersonal relationship skills
- Self-awareness
- Empathy
- Coping with emotions
- Coping with stress

### Don't Just Talk About IT... Do It!

**Evidence shows that including skills in programming is more effective than that of offering information alone. Researchers in Africa compared a lecture on AIDS prevention with a session in which students put a condom on a model and practiced negotiating condom use. When measured four months later, those who took the training in skills course knew more about condoms and reported having fewer sexual partners than did those who had attended only the lecture. In the United States, a survey of programmes concluded that the most effective ones used teaching methods that involved students directly and included modeling and practice in communication, negotiation, and refusal skills.**

## 7. Use peer approach in programme development and implementation

Programmes are more effective if adolescents play a major role in them and take some responsibility for their effectiveness. Adolescents may help shape the programme, design materials, give presentations, and serve as role models for responsible behaviour, thereby influencing programme-wide attitudes and behaviours.

Numerous studies show that peer education is an effective way to help youth develop healthy behaviours in areas such as sexual health, violence prevention and drug abuse prevention. Peer education draws on the credibility young people have with their peers, leverages the power of role modeling, and provides flexibility in meeting diverse needs for today's youth. One analysis found that peer-based interventions can reduce HIV risk-associated behaviour, including increasing condom acquisition and condom use, and decreasing unprotected sexual intercourse, frequency of sexual intercourse and number of sexual partners.

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Using young people as a resource in the programme is a natural extension of peer relationships. Adolescents are used widely to help to meet the information requirements of other young people as they are more likely not to reprimand them for their questions, and may well be more understanding of the need for information than adults. To do this well, however, requires a partnership with adults, initially, to help to obtain and provide sound information from reliable sources, and for support to the young people providing such help, since they may be faced with situations which require more than straightforward information.

Peer counseling is harder to achieve, since it requires special training in counseling and psychological skills, adequate knowledge of adolescent needs, ways to meet these needs and how to know when to refer to others. This requires training, supervision and above all continuing support, since it can be a stressful and very demanding task.

## 8. Balance cognitive and affective-behavioural components

Numerous studies have shown that knowledge alone is not sufficient to change behaviour. Learning in the absence of affect is unlikely to influence behaviour. Thus, this requires educators to present students with an opportunity to explore their values, feelings and emotions regarding the subject matter.

Values are principles, standards, or qualities that are regarded by social groups as worthwhile and desirable and are deeply embedded in people's culture. These values, in general, change over time through a variety of factors. One's attitudes, interests, feelings, aspirations, beliefs and convictions and goals in life are indicators of the values everyone holds which form the basis for the decisions they make in life.

One important means to modify these values is through education. Values clarification, therefore, is important to deal with conflicting values. A model for values clarification is found in Part Three.

## 9. Provide good teacher training to develop an effective ARSH educator

### Teacher training needs

❖ **An effective teacher is the pivotal element in a functional reproductive health and human sexuality education programme.**

As outlined by Florida's Department of Education in their document, ***Human Sexuality Education; Elements of Effective Programmes-Hot Topics: Usable Research*** it is stressed that the human factor of contact between students and their teacher is the centre of a sexuality and reproductive health education programme. Training for reproductive and sexual health education instructors entails strong leadership and support from administration, careful selection of candidates for the job, thoughtful consideration of sensitive issues and how to explore those issues, and time for instructors to practice teaching methods with colleagues.

One element of preparedness that researchers consistently stress is a strong comfort level with the topic of sexuality. Yet, as observed earlier, many cultures themselves do not seem to be comfortable with this topic. Raising the issue and increasing the comfort level of teachers with the topic of sexuality must be one of the central missions in a sound training programme.

Other goals noted for teacher training include:

**Goals of Teacher Training**

- **Providing accurate information about human sexuality**
- **Developing effective classroom skills**
- **Advising on teaching materials and methods**
- **Developing comfort with reproductive and sexual health issues**
- **Developing competence in reproductive and sexual health language**
- **Informing on school and community policies**

*Providing accurate information about human sexuality*

- Information and facts about biological, psychological, ethical and sociological development as foundations of sound information on human sexuality including but not limited to reproduction, childbirth, body image and self-concept, families, interpersonal relationships, and related health issues.

***Developing effective classroom skills***

- Classroom and interpersonal skills to enable creation of an environment that keeps students involved and encourages expression of feelings, beliefs and attitudes; allows practice in developing communication and life skills; and, provides a place to explore dilemmas and conflicting perspectives.

***Advising on teaching materials and methods***

- Information about resource materials, support organizations and local experts to develop an effective programme should be provided, with guidelines and strategies for selecting and using these resources.

***Developing comfort with reproductive and sexual health issues***

- Increasing teachers' awareness and comfort with their own values regarding controversial human sexuality issues will improve their ability to accept and validate diversity in their students. Comfort with all aspects of sexuality education will help teachers to answer spontaneous questions in a sexuality class in a calm, knowledgeable and non-judgmental manner.

***Developing competence in reproductive and sexual health language***

- Knowledge of relevant language and an understanding of the importance of using accurate terminology will equip students to understand and communicate more effectively on sexual and reproductive health areas.

***Informing on school and community policies***

- It is important to clarify and acquaint teachers with school policies and procedures, including teachers' rights and responsibilities in helping students with sexual and

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reproductive health-related problems, particularly in cases of new teachers and new programmes.

**Items to Assess**

- Changes in teachers/educators knowledge;
- Changes in perceptions (liberal versus conservative);
- Attitude change;
- The importance of adolescents learning about each item of sexual and reproductive health;
- Teacher's acceptance of responsibility to help youth learn and develop capacity in each area of sexual and reproductive health;
- Teacher intent to teach each topic;
- Level of comfort with course content and interactions with students.

When assessing the impact of a teacher training programme, the following items may be studied, and their relationships analyzed:

It is also important to be familiar with the questions commonly asked by young people. Many instructors teaching outside the traditional areas where sexuality and reproductive issues are explored – health, biology and physical education – may find themselves faced with questions and situation requiring a knowledgeable and comfortable posture towards adolescent sexuality and reproductive health. Disclosures by students amid positive relations between particular students are opportunities for positive development and should not be wasted due to teacher discomfort or lack of knowledge.

## Qualifications of an effective sexuality and reproductive health educators

Competent human sexuality educators are expected to:

- **Be knowledgeable about the physical, psychological, social, and moral dimensions of human sexuality and to possess positive attitudes that promote the goals of total sexual and reproductive health.**

A number of attitudes, skills and knowledge areas are required to be an effective sexuality and reproductive health educator. These include:

**Knowledge Objectives**

- Accurate, broad and up-to-date knowledge about reproductive health;
- Knowledge of influences, trends and issues of importance in the adolescent life-style;
- Knowledge of adolescent behaviour and attitudes in the area of sexuality and reproduction;
- Recognition of risk factors and status of health problems in the target population.

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## Attitudes Objectives

- Being comfortable with one's own sexuality and the language of sexuality;
- Being respectful of the diversity of backgrounds, values, beliefs, and behaviours of others;
- Being committed to the importance of family and community life education;
- Being supportive of parent's roles as primary sexuality educators;
- A trust in adolescents, female and male; a belief in their right and ability to make decisions for themselves;
- A commitment to empowerment.

## Skills Objectives

- Being skilled in communicating and teaching about human sexuality;
- Ability to facilitate meaningful and fair discussions;
- Able to generate respect from parents, students, and school administrators;
- Ability to help the learner recognize the issue and different viewpoints expressed in a free society;
- Ability to unjudgmentally help students analyze moral and ethical dilemmas;
- Ability to structure a warm and inviting climate for learning and the expression of feelings attitudes and beliefs.

## Choosing Good Sexuality Teachers

**Persons who express deep resentment about having to teach family life education, hold strong views about controversial (especially sex-related) issues and try to push them on others, inappropriately discuss highly personal information about themselves, and/or have unclear professional boundaries about relationships with students are not suitable candidates for the role. Schools must screen out such persons to avoid destroying the effectiveness of the programme.**

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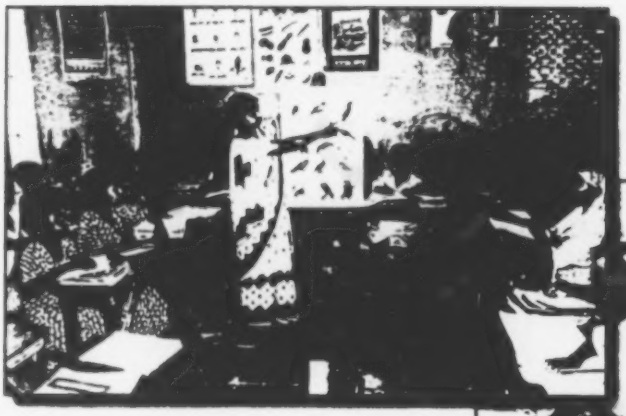
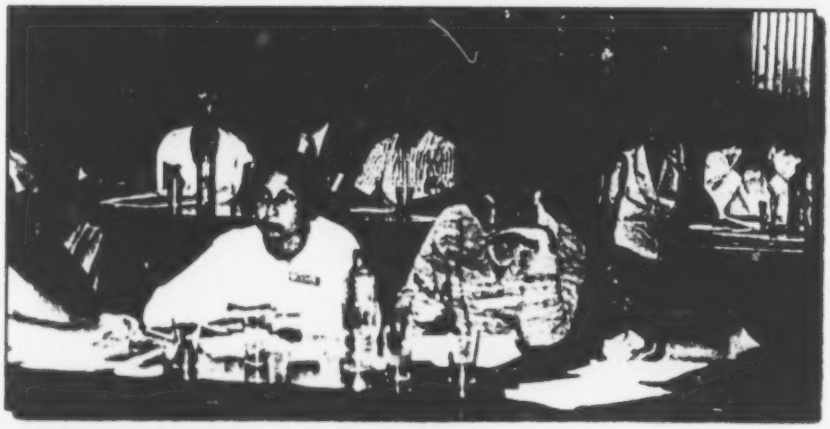




# PART THREE: ELEMENTS IN INCORPORATING REPRODUCTIVE AND SEXUAL HEALTH INTO CURRICULUM

In developing and assessing a proposed curriculum, the final plan should answer these questions:[44]

1. ***At what grade levels will the programme be implemented?***
2. ***What objectives and contents are appropriate for each grade level?***
3. ***How much time will be devoted to it?***
4. ***Will it be a separate course or integrated into other disciplines such as health, home economics, science, social studies, biology and/or physical education?***
5. ***What will be the most effective methodologies for teaching the various topics so that they impact on the acquisition of life skills among the learners?***
6. ***Who will teach human sexuality education and what kind of classroom environment should be created to foster open discussion?***

## ONE: Identifying Various Learner Groups and their School Levels

The identification of grade levels and the corresponding content areas for primary, junior and senior levels should be based on a comprehensive needs assessment of the target group. And based on the differences in needs and situations, contents can be presented following a spiral approach.

The spiral approach to curriculum development refers to the idea that many concepts have relevance for young people at many stages of their lives and that many skills are built on more basic skills learned at earlier ages. Thus, elementary students may be introduced to the correct name of parts of the reproductive system, while older students would be presented with more complex explanations on the functioning and processes associated with the system. Contraception activities for older students would be built on earlier-age discussions on the parts of the reproductive system.

The development of communication skills, for example, is life-long process. Elementary students may be taught the basics of identifying good and bad feelings, and practicing saying "no" to peer pressures. High schools students would build on these basic skills by practicing how to say no to sexual advances and developing communication skills needed to secure birth control services and counselling.

There are a number of ways of categorizing and understanding the different groups of adolescents.

### Understanding preadolescents

Although preadolescents have entered into the initial stages of the psychological turmoil of adolescence, most are still relatively calm. Most have not yet begun to actively rebel against adults or to develop romantic relationships. The pressure to "be cool," to be attractive to peers and to grow up quickly is beginning to intensify, however. Children this age have many questions about their bodies. They notice the obvious differences in development (physical, emotional and social) within their peer group and worry about changes happening too quickly or too slowly.

This is the period when basic life skills such as communication, problem solving, communicating about feelings, assertiveness, development of self-esteem, trainin, and anger control should be included. Also, in the anatomy and physiology area, these children have great curiosity about their own and the bodies of the opposite sex. Often understandings about their bodies and those of the opposite sex are shrouded in mystery. This stage is where many myths about reproduction and sexuality can take root in the absence of any reliable source of information. It is also the time where the message is received by observant pre-adolescents that topics of reproduction and sexuality are positive and welcome, or negative and best kept quiet about.

### Understanding adolescents

Adolescence may be loosely defined as the time from the point of the initial appearance of the secondary sex characteristics to that of sexual maturity. It is also a period where the individual's psychological processes and patterns of identification develop from those of a child to those of an adult. In the context of economics, it is a period of transition from the state of total socio-economic dependence to one of relative independence. Hence, the beginning is usually signified by the onset of puberty and ends with the ability to reproduce effectively.

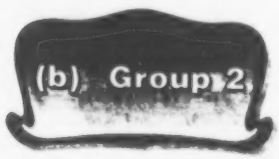
However, the transition to adult status is more ambiguous depending on the norms of a society. Hence, the duration of adolescence varies; it may be short as in societies where marriage customarily takes place soon after a woman reaches menarche and the marriage confers adult status. It may be extended as in societies where rapid social changes are taking place with modernization where young people go to schools and higher learning institutions to obtain higher degrees; acquire technical skills and achieve intellectual maturity before they can be eligible for the job market and become economically independent. Therefore, they tend to marry late.

### Understanding adolescents by level of sexual activity

To design effective programmes to improve adolescents' sexual and reproductive health, planners must take into account differences in young peoples' level of sexual activity. Depending upon their stage of individual development as well as their socio-cultural environment, adolescents' sexual experience and activity vary greatly. Upon examination,

three groupings of young people emerge, and the information, skills, and services needed differ for each group. In the report, ***Improving the Fit: Adolescent's Needs and Future Programmes for Sexual and Reproductive Health in Developing Countries*** by Hughes and MacCauley the need to consider the behaviour of the target group, including levels of sexual activity, is a key task in providing programming that is relevant and therefore likely to impact behaviour.[45]

Adolescents who have not yet begun having intercourse receive relatively little attention from those concerned about sexual and reproductive health programming for young people. This group includes primarily younger adolescents and can offer planners major opportunities for influencing the early formation of safe behaviours. Adolescents in this group needs information on counseling, and skills-building (both generic and specific to sexual and reproductive health). They do not yet need clinical services and are likely to be reluctant to go to clinical settings in any event, as was documented in a number of the studies.




Adolescents who have engaged in intercourse and have experienced no serious consequences need information, training in skills, and counseling, but of broader scope in each area. In addition, they need access to screening for STDs and, for girls, pregnancy testing. They also need reliable access to sexual and reproductive health supplies, that is, a choice of contraceptive methods and condoms for protection against STDs/HIV. Those with a wanted pregnancy, many of whom will be married or in consensual unions, need guidance on antenatal, obstetric and postpartum issues.

Adolescents who have engaged in intercourse and have experienced serious consequences such as cases of maternal morbidity and mortality, and of hospital admissions for complications of pregnancy, delivery, and abortion need access to the full range of clinical services as well as to information, training in skills and counseling.

A major consequence of teen sexual activity is adolescent pregnancy. Teachers need to be capable of recognizing the signs and symptoms of early pregnancy, which include breast tenderness, amenorrhea, abnormal menstrual pattern, nausea, and urinary frequency. Ectopic pregnancy must be distinguished from a normal intrauterine pregnancy, since it can result in death if undetected.

Depending on the cultural context and community, once an adolescent is pregnant there may be few supports available. The teacher and other health care practitioners must provide nonjudgmental information about all options, including carrying to term and caring for the infant, carrying to term for adoption, and abortion. Discussions with a pregnant adolescent should include discussion of future goals and how the pregnancy will affect those goals. Schools and teachers should explore positive and supportive ways to involve both teens and their families in decisions about pregnancy outcome and future adolescent parenthood. However, confidentiality of an adolescent's disclosure is very important in developing trust. Ideally the adolescent will involve a parent in making these decisions, but this is not always possible.

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The developmental stage of the adolescent is extremely important in these discussions. If possible, the adolescent should discuss her ideas with the practitioner rather than receiving a lecture. Young adolescents with concrete thought processes may not be able to anticipate or understand the consequences of their actions. They may have very unrealistic ideas about infants and fail to understand the impact that parenthood will have on their lives.[46]

## TWO: Deciding How to Integrate ARSH Contents Into the Curriculum

There are two basic approaches in incorporating reproductive and sexual health education contents in school curriculum.

### Integration into existing subjects

The first is to integrate reproductive and sexual health education objectives into existing programmes on health education, population education, family planning and education on HIV/AIDS. The advantage of this approach is that integrating with already established programmes may find more acceptance among schools, parents and the community. Most communities recognize the seriousness of the AIDS epidemic, for example, and accept and encourage HIV/AIDS education in the schools. Discussion of boy-girl relationships in classes on sexuality tend to raise more concern than the same discussions in family life or HIV/AIDS education classes.

Another benefits of the integration approach is that by establishing objectives in many different classes such as history, social studies and health education, the diversity of influences and implications to be explored in a comprehensive reproductive and sexual health programme are highlighted. Connections may be drawn when reproduction and sexuality programmes are housed in social sciences and family life education to show that reproductive and sexual health are bound up with many other aspects of our social, emotional and physical lives.

Moreover, teachers who explore these more sensitive and often ignored issues through teaching subjects such as health and family life may recognize the need for reproductive and sexual health education more readily than teachers from less related disciplines. Finally, by integrating reproductive and sexual health objectives into already existing programmes, a separate time period is not required, which may be difficult to arrange in already crowded class schedules as there is often a number of competing interests for available time slots.

There are also a number of potential disadvantages with this approach. The time available for topics in the reproductive and sexual health curriculum may be limited and as an 'addition' to the core programme may be relegated much less importance and attention needed to develop sufficient knowledge, attitudes and behaviours required for a healthy reproductive and sexual future. Teachers may also maintain biases or preferences for certain topics and approaches over others based on the traditional focus of the class, which may not necessarily take a sound and comprehensive approach to reproductive and sexual health topics.

### Establishing separate subjects

Separate subjects allow for total focus on the objectives of the reproductive and sexual health curriculum. Further, teachers who are selected and trained may also focus on

the exact skills required to teach the programme. Skills that require development can be narrowly focussed upon and reinforced using the full time period available. The needs of the students within the scope of reproductive and sexual health can dictate the content and emphasis of the classroom activities, without concern that time is being taken away from other core subjects.

However, separation of reproductive and sexual health topics from other subject areas supports the categorical perception that reproductive and sexual health is distinct from other aspects of life. Without a distinct effort to provide messages that highlight the social, historical and cultural dimensions of reproduction and sexuality, an essential element of reproduction and sexuality – that of its connection to many other aspects of our lives – may be lost. Another disadvantage of trying to establish separate classes may be the opposition of teachers and administrators who perceive an already crowded class schedule.

## THREE: Formulating Educational Objectives

The definition of reproductive and sexual health education presented in Part Two extends beyond the mere accumulation of facts and ideas. While knowledge is an important component of a good programme, in the past, many curriculums focussing on the reproductive and sexual needs of adolescents focussed exclusively on cognitive goals, emphasizing the gaining of knowledge through such activities as memorizing the reproductive system or listing the impacts of various STDs.

As studies have shown, a strictly cognitive approach to setting educational objectives has little impact on attitudes and behaviour. In many instances, increases in knowledge and even coupled with reported changes in attitudes do not necessarily lead to a change in behaviour. Young people may recognize the dangers of STDs for example and believe one should take precautions to protect oneself, yet continue to engage in unsafe sex due to lack of behavioural skills such as overcoming shyness in order to consult a counsellor or asserting oneself in the face of peer pressure to initiate sexual activities.

By including a focus on values and by addressing student's attitudes in concert with opportunities for practicing skills needed in their day to day lives, students are more likely to transfer their experience in the programme beyond the classroom to the social sphere where the majority of a young person's reproductive and sexual development takes place. Equipped even with the knowledge and motivation required to delay sex or protect oneself from pregnancy, the inability to act renders young people unable to respond to the reproductive and sexual health challenges faced in their particular socio-cultural environment.

Below are examples of the three main types of curriculum objectives to consider when designing adolescent reproductive and sexual health curriculums. This list provides only some selected examples under the three objective categories and should not be considered exhaustive.

## Knowledge/cognitive Objectives

- Gaining knowledge and understanding of reproductive anatomy and physiological processes
- Understanding the physical, emotional, psychological changes that occur in the body during puberty
- Identify ways and means to develop self-esteem and self concept
- Discuss pros and cons of early and late marriages and early pregnancy
- Differentiate between gender and sex and identify various sex stereotypes and how they affect boy-girl relationships
- Discuss differing values and attitudes toward sex and sexuality
- Identify safe and unsafe sexual practices
- Identify sources of reproductive health services in your community
- Examine various contraceptive methods and pros and cons of each method

## Attitudinal Objectives

- Develop personal and interpersonal attitudes such as value of self-control; value of delaying sexual activity; value on taking personal responsibility for personal action and managing desire for early pregnancy
- Develop healthy, assertive interpersonal relations such as value a healthy, non-violent life style; respect differences and value equality of all family members; value equitable, considerate interpersonal relationships
- Raise interest and intent to use protection at first intercourse
- Develop gender relations and equality such as respect for the opposite sex, including respect for the individual, value the rights, abilities, self-worth and self-esteem of each person; the recognition and rejection of stereotypes, and assertive communication skills
- Modify young people's perception that they are invincible and that risky behaviour applies to them

## Behavioural Objectives

- Develop assertiveness and other communication skills to resist peer pressure
- Develop problem solving and decision-making skills surrounding issues such as when to engage in sexual activity, when to get married and how many children to bear
- Learn and practice interacting with opposite sex in respectful ways and practice self control
- Avoid illness and diseases, injury (sexual abuse and violence) related to sexuality and reproduction
- Develop capacity for healthy, equitable and responsible relationships and sexual fulfillment
- Practice and develop self-esteem and positive self-concept
- Adopt safe sex practices such as abstinence, delayed sex and use of contraceptives
- Develop capacity to make choices with regard to reproductive and sexual health


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# FOUR: Identifying Contents for Various Objectives and Grade Levels

**Matching contents to the age and development level of students**

In the area of human and sexual development for example, younger students would be introduced to the names and basic functions of the human reproductive system, bodily changes that occur during puberty, family roles and relationships, and threats to health, including basic information on STDs and HIV/AIDS. Early messages on the differences and similarities in individual bodies and acceptance of these is important in developing positive body image and self-esteem. Communication, awareness of feelings, limits to friendship and assertiveness training (i.e. saying "no") may also be introduced at the elementary level.

Junior and senior students require more information on loving, dating, boy-girl relationships, conception, protection from disease and as they are or will soon be facing issues of sexual orientation in themselves and peers. Pre-adolescents and adolescents need to explore issues of sexual orientation and tolerance. A thorough presentation of contraception process and methods, the impacts of pregnancy and parenthood, and media messages regarding sexuality and body image are among the appropriate and necessary topics at this age level.

As for topic cluster on relationships, elementary age students require an understanding and practice in managing the relationships of importance at their stage of development: family, friends and identification of early community relationships and support. This exploration can introduce concepts of different roles in the family, definitions of a good friend and what the community can offer a young person at this age level. Communication between friends and family should also be explored and practiced in terms of acknowledging good and bad feelings, expressing likes and dislikes and developing basic social skills such as acceptance and acknowledging differences.

Junior and senior students are facing more complexities in their relationships and require exploration of differences and conflicts that can arise in family, friend and community relations. This is also the time when life skills needed for planning one's future and career path can be taught. Adult-level relationships and life experiences such as sexual experience issues, marriage and the impact of socio-cultural messages on gender and male-female relations are further appropriate topics.

Below is a shoplist of suggested topics organized by major reproductive and sexual health concerns proposed by the World Health Organization. To show an overall view of contents, objectives and grade levels, a matrix of curriculum contents is provided on page 48.

**Human and Sexual Development**

- **Reproductive anatomy and physiology**
- **Conception, pregnancy and births**
- **Puberty and physical, psychological, socio-cultural changes**
- **Body image, self-awareness, and self-esteem**
- **Sexual identity and orientation (gender issues, homosexuality, etc.)**

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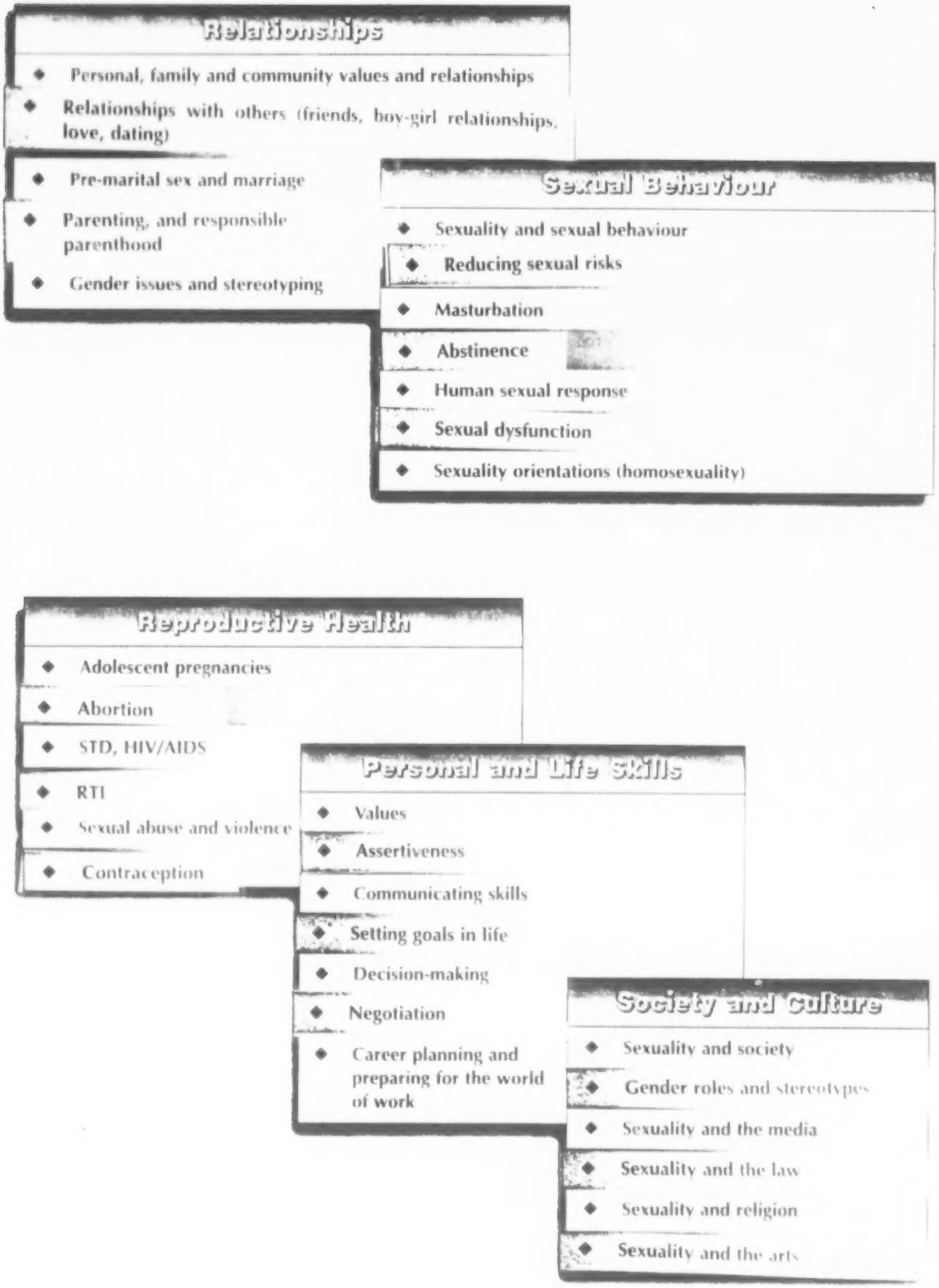


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# FIVE: Identifying Effective Teaching Strategies and Techniques

Traditional programmes on reproduction and sexuality utilized blackboard and lecture format, which had some impact on knowledge, but did little to change attitudes and behaviour. A more participatory approach, employing values exploration, active learning strategies such as role playing and community visits for example, are more likely to result in equipping young people to function effectively in life.

## Life skills

The teaching of "life skills" has received increased attention among educators in recent years. As opposed to academic skills such as geography and math, life skills are fundamental skills required to cope with life and are directly transferable to a student's personal and social existence. Life skills suggest the ability to act, not just to understand.

In a unit on coping with peer pressure, for example, the traditional approach might be to lecture on the need to reject unhealthy behaviour and avoid developing friendships with those with unhealthy attitudes. A life skill approach is more comprehensive and provides opportunities to learn skills such as saying 'no' and negotiating through an activity such as role playing. Practicing skills, rather than solely relying on information is a key element of the life skills approach.

Life skills may include the communication skills required to negotiate and express wants and needs with one's peers and partner, and the ability to access support services confidently. Even if a young person accepts the need for healthy behaviour, failure to reach one's goals may result if these essential life skills are inadequate. Research shows, for example, that students can enhance their ability to avoid risk-taking behaviour by using role playing extensively both to personalize information and learn skills.

Analysis of the life skills field suggests that there is a core set of skills that are at the heart of skill-based initiatives for the promotion of the health and well-being of adolescents. The World Health Organization book entitled, ***Life Skills Education in Schools*** (1997) list these as.

**Contents**

- Decision making
- Problem solving
- Creative thinking
- Critical thinking
- Effective communication
- Interpersonal relationship skills
- Self-awareness
- Empathy
- Coping with emotions
- Coping with stress

## Role-play

Role-play is also an educational technique which allows the participants to play themselves or other people in different or unknown situations, such as school students preparing for job interviews; to play the part of another person in a known situation, such as reversing roles so that students become teachers or children become parents; and to play other people in unknown situations, such as fantasy games or historical enactments.

By using role-play as an educational technique, emotions, reactions, thoughts, behaviours, attitudes and values can be explored. Role-play can be used as a base for discussion; it can increase communication skills and

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self-esteem; it demonstrates other situations and ways of dealing with them; and it allows participants to see how others feel in a given situation. The shared experience of a role-play can bring the group close together.

Role plays are effective most especially in bringing out gender equity (roles of fathers and mothers; male participation, double standard), or those dealing with safe sex such as practicing how to say "no" to any unwanted sexual activity, how to refrain from having sex when birth control is not available or when one is not ready for it, and how to insist on the use of birth control when having sex. Also, make sure everyone in the class has a role either as a participant in the role-play or as observers. And, have different persons play the same role to get different ideas and reactions to the role.

## Exploring values

A second area requiring attention in an effective reproductive and sexual health education programme is that of values. Values are attitudes, interests, feelings, aspirations, beliefs and convictions that drive or motivate us to act in certain ways. Many of these values are socially constructed. Because the values we hold form the basis for the decisions we make in life, it is important students have the opportunity to explore these, including the opportunity to explore socio-cultural influences on values formation.

### *A model for exploring values*

*1. Confronting a value situation*

This step involves recognizing that people can hold divergent views and each view has certain elements of truth. Every society has a set of values that has come down from earlier times. Some of them may still have a function in present day life and have survived the test of time. For others, there may be new knowledge, which has come to light showing that some values have been based on a mistaken view of reality and therefore are no more relevant to the present situation.

*2. Identify different alternatives*

Through discussion or other activity, the teacher encourages students to suggest different alternatives to the situation based upon their own ideas, convictions and values. Groups may be divided for a small discussion of the pros and cons of each alternative and takes a particular position on the alternative. Students should record the reasons for accepting and rejecting particular alternatives.

*3. Choosing freely among the alternatives*

Each group presents their position in the class. After a thorough class discussion, agreement may be reached on the best alternative for the particular conditions. It is also possible that no agreement is reached in the class on accepting one alternative – different students may express different values and reasons for holding their views.

*4. Prizing and cherishing*

People cherish decisions, which are in accordance with their values. Whatever choice is made after careful thought and discussion, it should be affirmed publicly without any obsession or feeling of guilt. One should feel happy about the decision/position taken.

*5. Acting upon the choice*

This is the most important part in the valuing process. Any value clarification exercise should culminate in an action following from the values identified.

**Problem-solving, decision-making and thinking skills**

Life is full of problems and decisions, and many people do not have the appropriate skills to manage these. Solving problems and making decisions are skills that can be taught and reinforced through practical applications to day-to-day life.

***A problem-solving model***

**The first step to resolving a problem is to identify the core problem and who owns it.**

Adolescents and children often have difficulty identifying the problem and taking ownership of it. Many young people confuse blame or fault with problem ownership. For example, when a boy is bothering a girl, the girl will often identify the boy as the owner of the problem – she confuses the cause of the problem with the ownership of the problem. It is necessary to show children that when they feel uncomfortable or are having difficulty in a given situation they have a problem that must be dealt with.

**The second step is to generate ideas, choices and option to deal with the problem.**

Young people also often recognize choice when responding to a problem, particularly those highly charged with emotion or peer pressure. Also, when a student confuses ownership of a problem by blaming a person or situation for the problem, they are likely to have difficulty generating a range of possible solutions. Students need to be assisted to come up with creative ways to solve problems. By generating many possible solutions to a given problem and considering the implications of each alternative, students become aware that they have free choice and power to solve their own problems. The ability to solve problems and see choices in a given situation is very connected to self-esteem and the ability to resist peer pressure.

A useful way to develop problem-solving and decision-making skills is to present a dilemma situation. This simulates a process that can be used in real-life situations.

**The Decision-Making Process**

Below is a more sophisticated description of the decision-making model found in ***When I'm Grown, A Curriculum for Teaching Life Planning (1992)*** from the Center for Population Options:

1. **Define the problem. State exactly what the problem is or the situation around which a decision needs to be made.**

2. **Consider all alternatives. List all possible ways to resolve the problem or possible decisions that could be made. Information may need to be gathered so that all alternatives can be considered.**

3. **Consider the consequences of each alternative. List all the possible outcomes-both positive and negative-for each alternative or each course of action that could be taken. It is important to have correct and complete information by this point.**

4. **Consider personal and family values. Be particularly aware of personal and family values when considering the consequences of alternatives. Decisions are not made in a vacuum. Consequences of decisions include the impact on significant relationships, e.g. parents, siblings, friends, partners, etc. or consistent with moral/religious upbringing or with what significant others would want us to do.**

5. **Choose one alternative. After carefully considering each alternative, choose the alternative that is most appropriate based on personal knowledge, values, morals, religious upbringing, present and future goals and the effect of the decision on significant others.**

6. **Implement the decision. Do what is necessary to have the decision carried out the way intended. It may be necessary to develop a step-by-step programme with a timetable to make sure things get done.**

## Suggested teaching materials

### *Videos, films and music*

Most young people enjoy and respond to videos, films and music. There is a wide range of relevant and informative videos available which can enhance reproductive and sexual health education. If videos are used, follow them with relevant activities which will clarify and offer additional information, explore values and attitudes, and provide opportunities for young people to share their opinions and feelings. Sections of television programmes or magazines may also be used, especially to review messages found in the media on sexuality and reproductive issues.

Always preview the material. Titles, and even summaries, can be misleading and content can be incorrect and out of date. Know why it was chosen and what it is hoped the group will gain. Be aware that the video may be appropriate for several topic areas, not just the stated title. Interrupt the screening if it is appropriate. Even if you have seen the video several times, it is important to stay in the room to gauge the reaction of that particular group. It may be advantageous to show it more than once in a course to clarify items that may have been missed or not understood.

Some suggested follow-up activities:

- At the end of the video, and before any discussion, ask individuals to write their reactions and feelings about it. Then ask participants to form small groups to share and compare their reactions. Allow time for total group sharing if appropriate. Role-play can be used to complement or expand a video. Have the group act out a range of other possible endings for it or different characters to replace the ones seen in the film or video. Prepare a questionnaire that reviews the content of the video. For younger students, a comic strip may be produced to ensure students understood the sequence and content found.



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### Healthy Music

**One of the oldest and most effective ways of reaching youth is through songs. Songs have been used effectively in Asia to educate on sexual health and population issues. In the Philippines, a popular singer, Lea Salonga with a rock group, the Menudo, from United States recorded a song video and MTV dealing with responsible sexual behaviour. In Viet Nam, the Youth Union produced cassette tapes and musical videos on these topics which have become very popular. Using popular styles of music such as rap, folk, rock, hip-hop and dance music can help break the ice and elicit empathy and more active participation from the students. Students could also design music posters or Compact disc covers with gender or sexual health messages. Songs could be presented in performances to the class or parents and at community events.**

*Visiting speakers*

To supplement a reproductive and sexual health education course it can be useful to involve visiting speakers. There are many benefits to be gained from having a visiting speaker. Contact with a person who has broader experience and specialized knowledge gives the participants an opportunity to gain insight into, and understanding of this experience. Visiting speakers can be part of the educator's support system and if a teacher feels unfamiliar with a subject, a guest speaker can provide a role model for future presentations. At the same time, the participants get the information required. Very often, teachers are not very familiar with reproductive health issues, being a new subject area. Speakers from the family planning and reproductive health programmes from the ministries of health or NGOs can be invited.

Be aware that there are some limitations. The speaker may present a one-sided view on the subject; teachers may be unfamiliar with their skill in presentation and you are dependent on them to present their information. Therefore, if necessary, invite a variety of speakers to cover different aspects of a topic; contact the speaker to familiarize yourself with the style and content to be used; and always have an alternative activity planned in the event that the speaker does not arrive.

## SIX: Fostering Good Classroom Environment

A warm, friendly classroom environment enhances reproductive and sexual health education. The way the room is physically structured can either limit or enhance group interaction. Whenever possible check on the room prior to planning the session. Decide what is to be achieved and set up the room accordingly.

If it is a formal lecture, panel or film, ensure that everyone can see and hear properly. For informal discussions don't attempt it with the participants sitting in rows. Stack the tables and arrange the chairs in a circle. A change in environment communicates to students that the activities that will be done in the class are different from traditional reading and writing lessons. Many classrooms have a room or section set aside for discussion groups and active learning with decorations and comfortable chairs.

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## Using an Anonymous Question Box

**A box labeled 'Questions and Comments' may be placed in some accessible unobtrusive spot, possibly near a door or at the back of the classroom. Make it clear to students that every question put into the question/feedback box will be discussed at sometime during the unit and within a certain time period (i.e. one day, one week, etc.). It might be a good idea on the first few days to ask everyone to put a question or comment in the box as they leave the room, simply to establish the routine. Some students may 'manage' the question box, by emptying the box daily or by organizing questions for the teacher's or student committee review. Try to establish everyone's participation as a matter of routine.**

### What language will be used?

The language a teacher of adolescent sexuality and reproductive health will encounter may range from technical terms, to slang, to baby talk. Many young people are not familiar with technical terminology. This puts them at a disadvantage so it may be appropriate to start by clarifying slang and colloquial words so everyone in the group is aware of the subject of the discussion. Teachers should not judge or look down on those using inaccurate or rude language as this will inhibit future communication. Simply point out correct terms by noting there is another word for that and explain the meaning of the word fully.

Be aware that language maintains sexism: always referring to doctors as 'he' implies that all doctors are male. Language also maintains heterosexism: that is, it validates the assumption that sexual relationships are always between members of the opposite sex. Sexual relationships in many classes are almost always discussed in terms of boyfriend and girlfriend or wife and husband. Use language with care and remove sexist and heterosexist terms to include a wider range of people in discussions. The recognition that sexist and heterosexist language excludes some people is an important part of adolescent reproductive and sexual health education.

### What questions to ask?

Direct questions, which are commonly used in traditional school subjects such as math or science to check the student's understanding are often not appropriate in the sensitive area of reproductive and sexual health education. Do not ask individual students to reveal information about themselves unless they voluntarily offer to once a safe and comfortable working environment is established. Never get angry with a student for refusing to answer a question on an area of sexuality or reproduction.

Questions should also be open-ended allowing a range of 'correct' answers. With traditional school subjects such as math and science dominating studies, students have come to believe that in all subjects there is only one 'right' answer. In areas of feelings and values there are a range of possible responses to questions and situations.

### Fostering a positive learning climate

In order for the students to feel safe about participating fully in the reproductive and sexual health programme, a feeling of group unity and positive learning environment should be developed.

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The following guidelines will help foster that kind of climate:

- Model a style of open communication by sharing appropriate information.
- Let the students know what they will be doing and what will be expected of them over the duration of the programme.
- Communicate enthusiasm about this special opportunity to discuss important topics. Point out how seldom they have a chance to talk about their feelings, especially in areas as personal as family, friendship and sexuality. Sexuality and reproduction, gender and culture, the role of the media and other related topics are a great break from math!!
- Establish ground rules for group communication and interaction that will make it easy for students to share openly and safely. Ask group members to develop their own list of rules using their own words.

**Examples of Open-ended, Non-personal Questions Include:**

- **What might a person think/feel?**
- **Who might a person talk to?**
- **What might their partner/friend/parent/ teacher/community leader think?**
- **Who might support a person?**
- **Who might cause problem for the person?**
- **Why do people sometimes find it difficult to...?**
- **What do people say...?**
- **I wonder what would happen if a person...?**

**Typical ground rules**

The following basic ground rules excerpted from the publication, ***When I'm Grown: Curriculum for Teaching Life Planning (1992)*** from the Center for Population Options suggests:

**Confidentiality:**

What is shared in the group will remain in this group. It is fine to talk in general about what happens during the discussions and activities of the programme, but individual names of students should not be used outside the class.

**Openness and Privacy:**

It is important to be open and honest in group discussions, but everyone has the right not to answer questions they feel are too personal, including the teacher leader.

**Nonjudgmental Approach:**

It's OK to disagree with another person's point of view, but not to judge or put down someone whose opinion differs.

**Right to Pass:**

This programme is designed to encourage participation, but it's OK to "pass" or to say "I'd rather not do this activity" or "I don't want to answer that question."

**All questions are OK:**

All questions will be answered. It's OK to ask anything, no matter how silly it may seem; chances are someone else wanted to know the same thing.

**Feelings are OK:**

It's OK to feel embarrassed or uncomfortable; even adults can feel uncomfortable when talking about sensitive topics like values and sexuality.

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# CURRICULUM CONTENTS

**Below is a sample matrix of curriculum contents, objective and core areas on adolescent reproductive and sexual health education. The entries on topics and objectives are only a selected few just to give the readers an idea of the range of topics that could be considered in developing an adolescent reproductive and sexual health curriculum. The readers are also urged to identify themselves which topics could be introduced at different grade levels.**

| Core Areas | Objectives | Topics and Issues |
|---|---|---|
| **I. Human and Sexual Development**<br>◆ **Reproductive anatomy and physiology**<br>◆ **Puberty and physical, psychological, socio-cultural changes**<br>◆ **Conception and pregnancy**<br>◆ **Development of self-awareness and self-esteem** | ◆ To identify basic structures of the male and female reproductive system.<br>◆ To identify physiological and emotional changes taking place during puberty.<br>◆ To encourage greater acceptance of individual differences in adolescent physiological and emotional changes.<br>◆ To learn how to care for sexual and reproductive organs.<br>◆ To describe how human reproduction occurs.<br>◆ To give girls and boys a chance to discuss any personal concerns and questions about puberty in a group of same sex peers.<br>◆ To help to be aware of the body changes associated with the menstrual cycle.<br>◆ To develop self-awareness and self-esteem. | ◆ Human anatomy and how it relates to sexual and reproductive development.<br>◆ Functions of the reproductive systems of both sexes.<br>◆ Physiological, emotional, social, psychological changes during puberty.<br>◆ Care for sexual and reproductive organs.<br>◆ Human reproduction and conception.<br>◆ Myths and misconceptions to explore in each culture about physiological changes and menstruation.<br>◆ Greater understanding and sensitivity about menstruation, particularly among boy will help to develop strong and positive relations between woman and men.<br>◆ Definition of self-esteem and self-awareness.<br>◆ Ways and means by which young girls and boys can develop their self-esteem. |
| **II. Family Life and Relationships**<br>◆ **Personal, family and community values and relationships** | ◆ To clarify the definition of family.<br>◆ To better understand family relationships and responsibilities.<br>◆ To identify values learned from families.<br>◆ To appreciate the similarities and differences among families and family members.<br>◆ To develop skills to deal with the conflicts and changes that occur in families over time. | ◆ Definition and functions of family.<br>◆ Family cycle and family resources.<br>◆ Privileges, responsibilities and challenges in family membership.<br>◆ Similarities and differences among families and family members.<br>◆ Conflicts and changes that occur in families are normal and need to be explored.<br>◆ Families should promote a sense of family pride. |

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| Core Areas | Objectives | Topics and Issues |
|---|---|---|
| ◆ **Relationships with others (friends, boy-girl relationships)** | ◆ To respect differences and value equality of all family members and equitable, considerate interpersonal relationships.<br>◆ To identify the components of positive friendships and relationships.<br>◆ To explore feelings about relationships.<br>◆ To clarify what level of intimacy might be appropriate for them and to reinforce their right to set their own limits.<br>◆ To practice skills important for developing and maintaining friendships.<br>◆ To recognize different kinds of friends.<br>◆ To understand what enhances or damages a relationship.<br>◆ To develop healthy understanding of their sexuality particularly as they relate to opposite sex. | ◆ Family values.<br>◆ Positive friendships and different kinds of relationships.<br>◆ Maintaining friendships.<br>◆ Love and dating.<br>◆ Friendships have limits which must be explored individually.<br>◆ Young people have choices about the level of intimacy in relationships. |
| ◆ **Community values** | ◆ To explore what citizenship and community mean.<br>◆ To define communities based on relationship.<br>◆ To be aware of community organizations and what they provide.<br>◆ To identify the community resources and services of use to adolescent girls.<br>◆ To identify women leaders or leadership groups in the community, particularly groups working on behalf of girls and women. | ◆ Definition of citizenship and concept of community.<br>◆ Benefits and values of community organizations.<br>◆ Shared responsibilities between men and women in community affairs.<br>◆ Community resources available and sensitivity to male and female adolescent need.<br>◆ Women leaders in the community. |
| **III. Human Sexuality**<br>◆ **Sexuality and sexual behaviour**<br>◆ **Reducing sexual risks**<br>◆ **Masturbation**<br>◆ **Abstinence** | ◆ To define what human sexuality is and how it affects our behaviour.<br>◆ To describe different kinds of sexual behaviour.<br>◆ To dispel myths related to sexuality and reproduction. | ◆ Definition of human sexuality.<br>◆ Various kinds of sexual behaviour.<br>◆ How good knowledge of human sexuality can promote sound physical and emotional development. |

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| Core Areas | Objectives | Topics and Issues |
|---|---|---|
| ◆ **Human sexual response**<br>◆ **Sexual dysfunctions**<br>◆ **Sexuality orientations** | ◆ To recognize and articulate some of the emotions that accompany adolescence sexual development.<br>◆ To acknowledge the existence of sexual feelings.<br>◆ To draw out the consequences of the decision to have sexual intercourse and to go into pre-marital sex.<br>◆ To identify what is safe and unsafe sexual behaviour and how to reduce sexual risks.<br>◆ To identify different kinds of sexual dysfunctions.<br>◆ To reinforce the facts about how women and girls can get pregnant and to emphasize responsibility of both sexes.<br>◆ To promote tolerance of all sexual orientations.<br>◆ To enhance young peoples' self-esteem by developing greater acceptance of their own sexuality regardless of sexual orientation.<br>◆ To introduce the correct sexual terms and to increase comfort with them. | ◆ New sexual feelings can be very powerful with broad implications on one's life.<br>◆ Myths and misconceptions on sexuality.<br>◆ Sexual feelings such as masturbation, wet dreams, etc.<br>◆ Human sexual response.<br>◆ Sexual dysfunctions.<br>◆ Safe and unsafe sex and reducing sexual risks.<br>◆ Having or not having sexual intercourse involves a decision.<br>◆ Both genders are responsible in sexual relationships.<br>◆ Young people require creative problem-solving and decision-making skills in the area of sexuality.<br>◆ Sexual orientation should not be attacked; all sexual orientations require love and support. |
| **IV. Reproductive Health and Family Planning**<br>◆ **Adolescent pregnancies**<br>◆ **Understanding conception**<br>◆ **Abortion**<br>◆ **STDs/HIV/AIDS**<br>◆ **RTI**<br>◆ **Sexual abuse and violence**<br>◆ **Contraception**<br>◆ **Understanding human rights** | ◆ To define what reproductive and sexual health means.<br>◆ To identify positive health habits.<br>◆ To identify the different risks and hazards to general and reproductive health.<br>◆ To identify safe and unsafe sexual practices and adopt safe sex practices.<br>◆ To identify sources of reproductive health services and information resources in the community.<br>◆ To modify perception that young people are invincible and that risky behaviour does not apply to them.<br>◆ To understand the process of conception, and thus a clearer understanding of how contraception works. | ◆ Definition of reproductive and sexual health and what it covers.<br>◆ Different types of health hazards and how to deal with them.<br>◆ Different places to go to for health information and services.<br>◆ Risks from being sexually active.<br>◆ Safe sex practices such as abstinence, delayed sex and use of contraceptives.<br>◆ Process of conception and human reproduction.<br>◆ Safe motherhood and prenatal and antenatal care for the pregnant adolescent.<br>◆ Contraception and different types of contraceptive methods.<br>◆ Advantages and disadvantages of contraceptive methods. |



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| Core Areas | Objectives | Topics and Issues |
|---|---|---|
| | ◆ To discuss the pros and cons of early marriage and adolescent pregnancy.<br>◆ To describe how selected factors influence a healthy pregnancy.<br>◆ To examine choice and alternatives for childbirth and bonding.<br>◆ To identify different kinds contraceptive methods.<br>◆ To weigh the advantages and disadvantages of different kinds of contraceptive methods.<br>◆ To learn where to go and how to avail of family planning services.<br>◆ To develop young people' skills of correct contraceptive use.<br>◆ To understand sexually transmitted diseases.<br>◆ To increase knowledge of how sexually transmitted diseases are transmitted.<br>◆ To identify feelings and attitudes about sexually transmitted diseases.<br>◆ To develop awareness of factors affecting the transmission of HIV/AIDS.<br>◆ To learn about the way a healthy immune system works and to demonstrate the impact of HIV/AIDS on a healthy immune system.<br>◆ To provide opportunities for young people to gain knowledge of the resources related to STDs available in the community.<br>◆ To increase sensitivity to others who are sick and to provide ideas for compassionate behaviour toward sick people.<br>◆ To define rights and responsibilities and understand that people should not violate others' rights.<br>◆ To help clarify the concepts of coercion and consent.<br>◆ To help prevent sexual abuse.<br>◆ To identify the feelings that sexual abuse engenders in the victim. | ◆ Different types of sexually transmitted diseases and how they are transmitted.<br>◆ Description of HIV/AIDS and how it is transmitted and prevented.<br>◆ Attitudes about sexually transmitted diseases.<br>◆ Characteristics in terms of transmission, symptoms and impacts on health.<br>◆ Young people must be open when describing the symptoms of STDs and accept the importance of seeking treatment of STDs.<br>◆ Definition of sexual abuse and causes.<br>◆ Widespread but often hidden problem of sexual abuse of young girls.<br>◆ Ways of handling sexual abuse.<br>◆ Relationship between anger and violence.<br>◆ There are many myths around violence.<br>◆ Coping with sexual abuse.<br>◆ Ways of handling anger. |

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| Core Areas | Objectives | Topics and Issues |
|---|---|---|
| | ◆ To identify ways to address sexual abuse.<br>◆ To identify causes of violence.<br>◆ To develop skills to manage anger nonviolently.<br>◆ To practice appropriate ways to handle anger.<br>◆ To develop greater awareness of the process of sexual pressure and date rape.<br>◆ To provide an opportunity to practice skills to counter potential pressure.<br>◆ To describe incidents of violence against young women around the world and in the local community and find ways to prevent being a victim of violence in themselves. | |
| V. **Responsible Parenthood** | ◆ To understand the concept of responsible parenthood.<br>◆ To show how responsibilities of parents differ from those of other-adults.<br>◆ To explore values and attitudes related to parenting.<br>◆ To identify the qualities and resources needed for parenthood.<br>◆ To evaluate the readiness of teenagers for parenthood.<br>◆ To promote the attitude that children need parents who are adults.<br>◆ To understand what life is like for a teenage parent.<br>◆ To appreciate what young babies are like and what they need from their caregivers.<br>◆ To analyze issues of teenage pregnancy.<br>◆ Roles and responsibilities of both parents in care of children. | ◆ Concept of responsible parenthood.<br>◆ Responsibilities of parents.<br>◆ Values and attitudes related to parenting.<br>◆ Resources needed for parenthood and numerous costs in raising a child today.<br>◆ Life of a teenage parent.<br>◆ Consequences of adolescent pregnancy.<br>◆ Stereotypes portrayed in the popular media about parenthood.<br>◆ Role of men in parenting. |

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| Core Areas | Objectives | Topics and Issues |
|---|---|---|
| **VI. Life Skills**<br>◆ **Values**<br>◆ **Assertiveness**<br>◆ **Communicating skills**<br>◆ **Setting goals in life**<br>◆ **Decision-making**<br>◆ **Negotiation**<br>◆ **Career planning** | ◆ To understand the meaning of values.<br>◆ To identify personal, family and cultural values and where they came from.<br>◆ To become aware of values and priorities.<br>◆ To rank the importance of various personal values.<br>◆ To examine the relationship between values and behaviour.<br>◆ To learn how to communicate about values to others.<br>◆ To practice accepting the values of others.<br>◆ To develop value of self-control and value of delaying sexual activity.<br>◆ To role-play assertive ways that young people can ask for what they want or need.<br>◆ To role-play assertive behaviours to refuse requests.<br>◆ To techniques that are often used to pressure people.<br>◆ To identify and practice assertive responses to pressure situations.<br>◆ To clarify what communication is and what makes it effective.<br>◆ To learn what good communication is and how good or bad communication makes us feel.<br>◆ To learn what body language is (nonverbal communication) and how to use it.<br>◆ To demonstrate the importance of being a good listener and to learn the skills needed to listen well.<br>◆ To practice expressing thoughts and feelings through "I statements".<br>◆ To learn the difference between assertive, aggressive and passive behaviour.<br>◆ To increase decision-making skills. | ◆ Different meanings of values.<br>◆ Different types of personal, family and cultural values.<br>◆ Ranking personal values and determining most and least important values.<br>◆ Values on sexual behaviour.<br>◆ Ways of being assertive.<br>◆ Situations where assertiveness is required.<br>◆ Assertiveness is a right and a necessary life skill.<br>◆ Assertiveness skills are appropriate for both female and male development.<br>◆ It is important to recognize arguments and tactics young people use to pressure other young people into sexual activity.<br>◆ How to be assertive in dealing with pressure situations.<br>◆ Meaning of communication and factors that contribute to its effectiveness.<br>◆ Meaning of body language and how it use them.<br>◆ Techniques in listening and expressing thoughts and feelings.<br>◆ Differences between assertive, aggressive and passive behaviour.<br>◆ Steps and procedures in decision-making.<br>◆ Psychological, physical, health and social outcomes of sexual Decision-making in sexual behaviour.<br>◆ Techniques in negotiation in sexual behaviour.<br>◆ Resisting influences and following through with decisions is an important skill which may be developed.<br>◆ Young people should engage in joint decision-making in friendships and relationships. |

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| Core Areas | Objectives | Topics and Issues |
|---|---|---|
| | ◆ To learn and practice a model for effective decision-making.<br>◆ To predict the consequences of certain decisions and how they might affect future life plans.<br>◆ To evaluate the arguments for and against having sexual intercourse as a teenager.<br>◆ To develop decision-making skills by encouraging them to assess positive and negative outcomes.<br>◆ To further develop young peoples' awareness of possible outcomes and consequences of sexual decisions.<br>◆ To practice the skill of negotiation.<br>◆ To understand what goals are and their importance.<br>◆ To learn a step-by-step process for setting and achieving goals.<br>◆ To practice applying the goal-setting model to a personal goal.<br>◆ To begin to identify goals for the future.<br>◆ To practice setting short-term goals and practice setting long-term goals.<br>◆ To broaden awareness of career options for the future.<br>◆ To increase knowledge of appropriate job behaviours and attitudes. | ◆ Negotiating an arrangement requires an outcome suitable to both people.<br>◆ There is a large difference between emotional and physiological 'readiness' for sexual activity.<br>◆ Definition of goals.<br>◆ Different kinds of goals, i.e., short-term and long-term goals.<br>◆ Process for setting and achieving goals.<br>◆ Procedures for applying goals in personal life.<br>◆ Goals dealing with studies and<br>◆ Showing how setting goals can help plan the future.<br>◆ Early parenthood can seriously alter life plans and goals.<br>◆ Identifying various career options.<br>◆ Skills needed for obtaining job in the future. |
| **VII. Society, Culture, and Gender**<br>◆ **Sexuality and society**<br>◆ **Gender roles and stereotypes**<br>◆ **Sexuality and media**<br>◆ **Sexuality and the law**<br>◆ **Sexuality and the arts** | ◆ To compare how adults and adolescents see certain issues.<br>◆ To compare why adults and children have similar or differing points of view.<br>◆ To identify common views of adolescent girls held by the community and how these views enhance or constraints a girl's options.<br>◆ To identify the adults to go to for help.<br>◆ To identify young people' attitudes about gender roles and gender-role stereotypes. | ◆ Differences between adults and adolescents' perceptions on many issues on gender and sexuality.<br>◆ Identify adults who are considered influential and role models for adolescents.<br>◆ Meaning of gender and sex roles.<br>◆ Similarities and differences between boys and girls.<br>◆ Myths, stereotypes and prejudices on gender and sex roles.<br>◆ Traditional values that affect status of girls and women. |



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| | ◆ To differentiate between gender and sex roles.<br>◆ To identify various sex stereotypes and how they affect boy-girl relationship.<br>◆ To learn about and appreciate cultural and gender diversity.<br>◆ To examine the role of gender in distributing resources in the family.<br>◆ To learn how discrimination feels and to identify strategies for combating it.<br>◆ To develop greater awareness in young people of the ways gender stereotyping can limit expression of a range of feelings.<br>◆ To develop young people' awareness of the role of the media in reinforcing these stereotypes.<br>◆ To help young people explore the influence of the media on their self-image.<br>◆ To encourage greater acceptance of their own body image by helping young people become aware of the negative influence of media pressure.<br>◆ To explore how images portrayed in popular songs affect the behaviour of young people.<br>◆ To stimulate discussion on these images and how they maintain sex role stereotypes. | ◆ How gender stereotypes affect relationships.<br>◆ Cultural and gender diversity.<br>◆ Media's influence in sexual behaviour and reinforcing sex roles stereotypes.<br>◆ Many men and woman choose nontraditional occupations.<br>◆ There is no basis for the belief that one gender is somehow more important than the other.<br>◆ Laws exist in most cultures to support the rights of girls and women as do laws that are prejudicial to their rights.<br>◆ It is important of protecting individual rights. |

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